**FAIRFAX COUNTY HEALTH DEPARTMENT – SERVICE SLIP**

**CLIENT NAME:** _____ **DOB/:** ____/____/____ **PIN:** _____

| **BELOW TO BE COMPLETED BY HEALTH DEPARTMENT STAFF ONLY:** | | ☐ Private Insurance (see flow sheet) | |
|---|---|---|---|
| ☐ Client Pay/FAMIS **Guarantor 1** | ☐ Medicaid **Guarantor 2** | ☐ Anthem **Guarantor 13** | ☐ IN total Health **Guarantor 15** |

| CPT Codes | Catch Up | Vaccine | ICD-10-CM Codes | ADM Fee | DECLINED | MFG | Lot # | Expiration Date | Dose/Route | SOI | V-S-C-A-P-E | VIS Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 90625 | | CHOLERA (Vaxchora) | Z41.8 | ☐ | ☐ | | | | 100 ml/PO | | | |
| 90700 | | DTAP | Z23 | ☐ | ☐ | | | | 0.5 / IM | | | |
| 90696 | | DTAP-IPV | Z23 | ☐ | ☐ | | | | 0.5 / IM | | | |
| 90636 | | HEP A/HEP B (Twinrix) | Z23 | ☐ | ☐ | | | | 1.0 / IM | | | |
| 90632 | | HEP A - Adult | Z23 | ☐ | ☐ | | | | 1.0 / IM | | | |
| 90633 | | HEP A - (Child 1 thru 18) | Z23 | ☐ | ☐ | | | | 0.5 / IM | | | |
| 90746 | | HEP B – ADULT | Z23 | ☐ | ☐ | | | | 1.0 / IM | | | |
| 90744 | | HEP B – (Child 0 thru 19) | Z23 | ☐ | ☐ | | | | 0.5 / IM | | | |
| 90647 | | HIB (Ped Vax) | Z23 | ☐ | ☐ | | | | 0.5 /IM | | | |
| 90648 | | HIB (ActHIB) | Z23 | ☐ | ☐ | | | | 0.5 /IM | | | |
| 90651 | | HPV 9 | Z23 | ☐ | ☐ | | | | 0.5 /IM | | | |
| 90281 | | IMMUNE GLOBULIN | Z41.8 | ☐ | ☐ | | | | / IM | | | |
| 90738 | | JAPANESE ENCEPHALITIS | Z23 | ☐ | ☐ | | | | / IM | | | |
| 90707 | | MMR | Z23 | ☐ | ☐ | | | | 0.5 / SQ | | | |
| 90710 | | MMRV (12 mos. thru 12 yrs.) | Z23 | ☐ | ☐ | | | | 0.5 / SQ | | | |
| 90620 | | MENINGOCOCCAL B | Z23 | ☐ | ☐ | | | | 0.5 / IM | | | |
| 90734 | | MENINGOCOCCAL CONG | Z23 | ☐ | ☐ | | | | 0.5 / IM | | | |
| 90723 | | PEDIARIX (HEPB/DTAP/IPV) | Z23 | ☐ | ☐ | | | | 0.5 / IM | | | |
| 90698 | | PENTACEL (DTAP/IPV/Hib) | Z23 | ☐ | ☐ | | | | 0.5 / IM | | | |
| 90670 | | PNEUMOCOCCAL (Conjugate) | Z23 | ☐ | ☐ | | | | 0.5 / IM | | | |
| 90732 | | PNEUMOCOCCAL (Polysaccharide) | Z23 | ☐ | ☐ | | | | 0.5 /SQ | | | |
| 90713 | | POLIO | Z23 | ☐ | ☐ | | | | 0.5 /SQ | | | |
| 90675 | | RABIES | Z23 | ☐ | ☐ | | | | 1.0 /IM | | | |
| 90681 | | ROTAVIRUS (Rotarix) | Z23 | ☐ | ☐ | | | | 1.0 / PO | | | |
| 90714 | | TD | Z23 | ☐ | ☐ | | | | 0.5 / IM | | | |
| 90715 | | TDAP | Z23 | ☐ | ☐ | | | | 0.5 /IM | | | |
| 90691 | | TYPHOID INJECTABLE | Z23 | ☐ | ☐ | | | | 0.5 /IM | | | |
| 90690 | | TYPHOID – ORAL | Z23 | ☐ | ☐ | | | | / PO | | | |
| 90716 | | VARICELLA | Z23 | ☐ | ☐ | | | | 0.5 / SQ | | | |
| 90717 | | YELLOW FEVER | Z23 | ☐ | ☐ | | | | 0.5 / SQ | | | |
| 90736 | | ZOSTER | Z23 | ☐ | ☐ | | | | .65 /SQ | | | |
| 86580 | | TST GIVEN | Z11.1 | ☐ | ☐ | | | **TYPE: INITIAL / REPEAT / BOOSTER** | | **TIME PLANTED:** _____ | | |

_____ _____ ***SERVICE TIME (Minutes):*** _____ ***CHECKOUT:*** _____

*START TIME - (Ready for PHN)* *PROVIDER'S SIGNATURE* *(Time Spent with PHN)* *(Front Desk)*

***INTERPRETER:*** _____ ***DATE:*** _____

*(Name/Number)*

☐ **TST READ:** _____**MM** **DATE:** _____ ☐ **QFT** **OUTCOME:** ☐ ***Positive*** ☐ ***Negative*** ☐ ***Unreadable*** ☐ ***Indeterminate*** ☐ ***No Return***

_____ _____ ***SERVICE TIME (Minutes):*** _____ ***CHECKOUT:*** _____

*START TIME - (Ready for PHN)* *PROVIDER'S SIGNATURE* *(Time Spent with PHN)* *(Front Desk)*

***INTERPRETER:*** _____ *DATE:* _____

*(Name/Number*

**FAIRFAX COUNTY HEALTH DEPARTMENT – SERVICE SLIP**

**CLIENT NAME:** _____ **DOB/:** ____/____/____ **PIN:** _____

**RECORD KEEPING**

I understand that medical records will be retained for five years after the event. In the case of a minor the record will be retained 21 years after birth.

**CLIENT CONSENT FOR GENERAL PRIMARY CARE**

I hereby authorize the Physicians, Nurses, Nurse Practitioners, and other medical care providers of the Fairfax County Health Department (FCHD) to examine and/or treat me and/or my dependent, as named above.

**DOCUMENTATION OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received the Notice of Privacy Practices from the Fairfax County Health Department.

**NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING**

FCHD is required by § 32.1-45 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any FCHD health care professional, worker or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.

2. If you should be directly exposed to the blood or body fluids of a FCHD health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

**HIV TESTING**

If HIV testing is performed, you will be told ahead of time, be given information about the test, and allowed to decline testing. All results will remain confidential except as allowed by law.

I understand that this consent will remain in effect as long as my dependent or I receive care from FCHD or until I withdraw it.

_____ _____

Signature of Client, Parent/Legal Guardian, or Person Acting in Loco Parentis — Date Signed

_____ _____

Relationship (if signature is not of Patient) — Signature of Person Obtaining Consent

**COMMONWEALTH OF VIRGINIA**
**VOTER REGISTRATION AGENCY CERTIFICATION**

**If you are not registered to vote where you live now, would like to apply to register to vote here today?**
**(Please check only one)**

☐ I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.
☐ Yes, I would like to apply to register to vote. (Please fill out the voter registration application form)
☐ No, I do not want to register to vote.

_____ _____ _____

Applicant Name — Signature — Date

**PERMISSION TO SHARE SCHOOL AGED STUDENT'S IMMUNIZATION RECORDS**

"I authorize Fairfax County Health Department (FCHD) to release information my child's immunization record to school systems for the express purpose of meeting school entrance requirements."

_____ _____

Signature of Client, Parent/Legal Guardian, or Person Acting in Loco Parentis — Date Signed

**BELOW TO BE COMPLETED BY HEALTH DEPARTMENT STAFF ONLY:**

| CODE | LABORATORY | CODE | OTHER SERVICES | CODE | OTHER SERVICES (CONT.) |
|---|---|---|---|---|---|
| 84030 | HEMOGLOBIN | 90471 | ADMIN FEE- INITIAL | 99403 | INT CONSULTATION FEE (MD) |
| 86706 | HEPATITIS B SCREENING | 90472 | ADMIN FEE-ADDITIONAL | 99402 | INT CONSULTATION FEE (RN) |
| 86703 | HIV TESTING | MEDFORM | COMPLETION OF FORMS FOR COLLEGE ENTRY | MRX | MALARIA RX |
| 83655 | LEAD SCREENING | PAGE | COPYING CHARGE (1ST 50 PAGES) | LDMRFEE | MEDICAL RECORDS SEARCH & HANDLING FEE |
| 81025 | PREGNANCY TEST FP/MAT | PAGE50 | COPYING CHARGE (AFTER 50 PAGES) | S0250 | NURSING HOME SCREEN |
| 86480 | QUANTIFERON (IGRA) (circle) L or R | COU | COUNSELING STD/IMM/TB | 99211 | OFFICE VISIT |
| 86592 | SYPHILIS TESTING | DDW | DD WAIVER | ODOT | OFFICE DIRECTLY OBSERVED THERAPY |
| 86790 | RABIES TITER | HSI | HOMELESS SHELTER INITIAL | PHA | PH ASSESSMENT |
| 87491 | CHLAMYDIA/GONORRHEAL (URINE) | HSR | HOMELESS SHELTER RETURN | RSO | RISK SCREEN |
| ZIKA | ZIKA LAB TEST | IDC | INFANT DEVELOPMENT | | |