FAIRFAX COUNTY HEALTH DEPARTMENT – SERVICE SLIP

PATIENT NAME:_____ **DOB:**_____ **PIN:**_____

BELOW TO BE COMPLETED BY HEALTH DEPARTMENT STAFF ONLY:

CODE	IMMUNIZATION	CHARGE	X	IT	MFG	LOT #	DOSE	ROUTE	SOI	VFC	NVFC State	Non-VFC	VIS Date
90748	COMVAX (HEP B & HIB)		X				0.5	IM					
90700	DTaP		X				0.5	IM					
90636	HEP A/HEP B	C					1.0	IM					
90632	HEP A - Adult	C					1.0	IM					
90633	HEP A - (Child 1 thru 18)						0.5	IM					
90746	HEP B – ADULT						1.0	IM					
90744	HEP B – (Child 0 thru 19)						0.5	IM					
90648	HIB		X				0.5	IM					
90649	HPV		X				0.5	IM					
90281	IMMUNE GLOBULIN	C						IM					
90735	JAPANESE ENCEPHALITIS	C						SQ					
90707	MMR		X				0.5	SQ					
90710	MMRV (12 mos thru 12 yrs)		X				0.5	SQ					
90733	MENINGOCOCCAL POLY						0.5	SQ					
90734	MENINGOCOCCAL CONG (11-55 YRS.)						0.5	IM					
90723	PEDIARIX (HEPB/DTaP/IPV)		X				0.5	IM					
90698	PENTACEL (DTaP/IPV/Hib)		X				0.5	IM					
90669	PNEUMOCOCCAL Conjugate (VFC Elig)		X				0.5	IM					
90732	PNEUMOCOCCAL (POLYSACCHARIDE)						0.5	IM					
90713	POLIO INJECTABLE		X				0.5	IM					
90675	RABIES	C					1.0	IM					
90680	Rotavirus (VFC Elig. Only)		X				2.0	PO					
90681	Rotavirus (Rotarix) (VFC Elig. Only)		X				1.0	PO					
90714	Td		X				0.5	IM					
90715	TdaP						0.5	IM					
90691	TYPHOID INJECTABLE	C					0.5	IM					
90690	TYPHOID – ORAL	C						PO					
90716	VARICELLA						0.5	SQ					
90717	YELLOW FEVER	C					0.5	SQ					
90736	ZOSTER						.65	SQ					

86580	TST GIVEN								

TST CODES (Circle for current TST entry):

TYPE: INITIAL / REPEAT / BOOSTER ***TIME PLANTED:*** _____

TST READ: _____**MM DATE:**_____ **OUTCOME: POSITIVE / NEGATIVE / UNREADABLE / NO RETURN**

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

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

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

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

INTERPRETER NAME/NUMBER: _____ ***DATE:*** _____

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RECORD KEEPING

I understand that medical records will be retained for six years after the date of the last visit or for five years following patient's death. In the case of a minor, the record will be retained ten years after the last visit or for five years after age 18, whichever comes later.

PATIENT 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.

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 Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis Date Signed

BELOW TO BE COMPLETED BY HEALTH DEPARTMENT STAFF ONLY:

CODE	LABORATORY	CODE	MATERNITY	CODE	OTHER SERVICES	CODE	OTHER SERVICES (CONT.)
84030	HEMOGLOBIN	99204	NEW	COU	COUNSELING STD/IMM	S0250	NURSING HOME SCREEN
86706	HEPATITIS B SCREENING	MATOP	INTAKE	HSI	HOMELESS SHELTER INITIAL	DDW	DD WAIVER
86703	HIV TESTING	99214	RETURN	HSR	HOMELESS SHELTER RETURN	90471	ADMIN FEE
83655	LEAD SCREENING			IDC	INFANT DEVELOPMENT	99211	IT CONSULTATION FEE
81025	PREGNANCY TEST FP/MAT	CODE	SCHOOL PE	MRX	MALARIA RX	99213	TB RETURN
		99383	5-11	RSO	RISK SCREEN ONLY	CODE	TATTOO PROGRAM
						15783	TATTOO REMOVAL

IMMUNIZATION HISTORY:		DATE(S) OF INJECTION(S)	IMMUNIZATION HISTORY:		DATE(S) OF INJECTION(S)
90701	DPT		90704	MUMPS	
90720	DPT/HIB		90669	PNEUMO (Conj)	
90702	DT		90732	PNEUMO (Poly)	
90700	DTap		90713	POLIO	
90633	HEPATITIS A		90675	RABIES	
90744	HEPATITIS B		90680	ROTAVIRUS	
90723	HEP B/DTaP/IPV		90706	RUBELLA	
90698	DTaP/IPV/Hib		90718	TD	
90648	HIB		90715	TdaP	
90748	HIB/HBV COMV		90691	TYPHOID, INJECT	
90649	HPV		90690	TYPHOID, ORAL	
90735	JAPANESE ENCEPHALITIS		90716	VARICELLA	
90707	MMR		90717	YELLOW FEVER	
90705	MEASLES		90736	ZOSTER	
90733	MENINGOCOCCAL				