Fairfax County Health Department-Service Slip

Patient Name: _____ **Date of Birth:** ____/____/____ **MRN:** _____

Below to be completed by Health Department Staff:		☐ Self-Pay	☐ Private Insurance (flow sheet)	☐ Uninsured	☐ Medicaid
☐ Sentara	☐ Aetna Better Health	☐ Molina	☐ Anthem Healthkeepers	☐ Kaiser	☐ United Heathcare

CPT Codes	Vaccine	ADM Fee	Declined	Dose #	MFG	Lot #	Expiration Date	Dose/Route	SOI	V-S-C-A	VIS Date
90593	CHIKUNGUNYA	☐	☐					0.5/ IM			
90625	CHOLERA (Vaxchora)	☐	☐					100 ml/PO			
91318	COVID PFIZER BABY 3 MCG	☐	☐					0.3/ IM			
91319	COVID PFIZER PEDS 10 MCG	☐	☐					0.3/IM			
91320	COVID PFIZER 30 MCG	☐	☐					0.3/ IM			
90700	DTAP	☐	☐					0.5 / IM			
90696	DTAP-IPV (Kinrix)	☐	☐					0.5 / IM			
90697	DTAP-HEP B-HIB-IPV (VAXELIS)	☐	☐					0.5 / IM			
90636	HEP A/HEP B (Twinrix)	☐	☐					1.0 / IM			
90632	HEP A - Adult	☐	☐					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			
90739	HEPLISAV-B	☐	☐					0.5 / IM			
90647	HIB (Ped Vax)	☐	☐					0.5 /IM			
90648	HIB (ActHIB)	☐	☐					0.5 /IM			
90651	HPV 9 (Gardasil)	☐	☐					0.5 /IM			
90281	IMMUNE GLOBULIN	☐	☐					/ IM			
90738	JAPANESE ENCEPHALITIS	☐	☐					/ IM			
90707	MMR	☐	☐					0.5 / SQ			
90710	MMRV (12 mos. thru 12 yrs.)	☐	☐					0.5 / SQ			
90620	MENINGOCOCCAL B	☐	☐					0.5 / IM			
90734	MENINGOCOCCAL CONG ACWY	☐	☐					0.5 / IM			
90623	MENINGOCOCCAL ACWYB (PENBRAYA)	☐	☐					0.5 / IM			
90611	MPOX (Jynneos)	☐	☐					0.1/0.5 ID/SQ			
90723	PEDIARIX (HEPB/DTAP/IPV)	☐	☐					0.5 / IM			
90698	PENTACEL (DTAP/IPV/Hib)	☐	☐					0.5 / IM			
90671	PNEUMOCOCCAL CONJ 15 (Vaxneuvance)	☐	☐					0.5 / IM			
90677	PNEUMOCOCCAL (Conjugate) 20	☐	☐					0.5 / IM			
90732	PNEUMOCOCCAL(Polysaccharide) 23	☐	☐					0.5 /SQ			
90713	POLIO	☐	☐					0.5 /SQ			
90675	RABIES	☐	☐					1.0 /IM			
90681	ROTAVIRUS (Rotarix)	☐	☐					1.0 / PO			
90679	RSV (AREXVY- ADULTS)	☐	☐					0.5/ IM			
90380	RSV (BEYFORTUS 50 MG)	☐	☐					0.5/ IM			
90381	RSV (BEYFORTUS 100 MG)	☐	☐					1.0 / IM			
90714	TD	☐	☐					0.5 / IM			
90715	TDAP 2nd TRI:Z34.92 3rd:TRI Z34.93	☐	☐					0.5 /IM			
90691	TYPHOID INJECTABLE	☐	☐					0.5 /IM			
90690	TYPHOID – ORAL	☐	☐					/ PO			
90716	VARICELLA	☐	☐					0.5 / SQ			
90717	YELLOW FEVER	☐	☐					0.5 / SQ			
90750	ZOSTER	☐	☐					0.5 / IM			
86580	TST GIVEN	☐	☐				**Type: Initial/Repeat/Booster** **Time Planted:** _____				

Provider's Signature: _____ **Date:** _____

Interpreter (Name/Number): _____ **Date:** _____

Fairfax County Health Department-Service Slip

RECORD KEEPING

I understand that medical records will be retained for 10 years after the event. In the case of a minor the record will be retained 28 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 Signed

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

NO PHOTO IDENTIFICATION AVAILABLE (Only required if no photo ID)

I am unable to provide a photo ID at this time.

_____ _____

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	TITERS	
84030	HEMOGLOBIN	90471	ADMIN FEE- INITIAL	86706	HEP B	
86706	HEPATITIS B SCREENING	90472	ADMIN FEE-ADDITIONAL	86735	MMR	
87389	HIV TESTING	MEDFORM	COMPLETION OF FORMS FOR COLLEGE ENTRY	86790	RABIES	
83655	LEAD SCREENING	PAGE	COPYING CHARGE (1ST 50 PGS)	86787	VARICELLA	
81025	PREGNANCY TEST	PAGE50	COPYING CHARGE (AFTER 50 PAGES)	86803	HCV	
86480	QUANTIFERON (IGRA) (circle) L or R	LDMRFEE	MEDICAL RECORDS SEARCH & HANDLING FEE	OTHER:		
86592	SYPHILIS TESTING	99403	INT CONSULTATION FEE (MD)			
87491	CHLAMYDIA/GONORRHEAL (URINE)	99402	INT CONSULTATION FEE (RN)			
87389	4th Gen HIV 1,2 AG/AB w/reflx	99211	OFFICE VISIT			
		3510F	RISK SCREEN ONLY			
			PRENATAL VITAMINS EXP DATE:		LOT #:	