

FAIRFAX COUNTY HEALTH DEPARTMENT – SERVICE SLIP

CLIENT NAME: _____

DOB: ____ / ____ / ____

PIN: _____

BELOW TO BE COMPLETED BY HEALTH DEPARTMENT STAFF ONLY:		<input type="checkbox"/> Private Insurance (see flow sheet)
<input type="checkbox"/> Client Pay/FAMIS Guarantor 1	<input type="checkbox"/> Medicaid Guarantor 2	<input type="checkbox"/> Anthem Guarantor 13
		<input type="checkbox"/> IN total Health Guarantor 15

CPT Codes	Catch Up	Vaccine	ICD-10-CM Codes	ADM Fee	MFG	Lot # /	Dose/Route	SOI	Funding Source Code V-S-C-A-P-E	VIS Date
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	Z23				0.5 /IM			
90649		HPV (quad)	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			
90733		MENINGOCOCCAL POLY	Z23				0.5 / SQ			
90734		MENINGOCOCCAL CONG (11-55 YRS.)	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 (VFC Eligible)	Z23				0.5 / IM			
90732		PNEUMOCOCCAL (POLYSACCHARIDE)	Z23				0.5 /IM			
90713		POLIO INJECTABLE	Z23				0.5 /IM			
90675		RABIES	Z23				1.0 /IM			
90680		ROTAVIRUS (ROTATEQ) (VFC Eligible Only)	Z23				2.0 / PO			
90681		ROTAVIRUS (ROTARIX) (VFC Eligible Only)	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: _____
_____ START TIME - (Ready for PHN)	_____ PROVIDER'S SIGNATURE	_____ SERVICE TIME (Minutes): (Time Spent with PHN)
		_____ CHECKOUT: (Front Desk)
INTERPRETER: _____ (Name/Number)		
_____ DATE:		
<input type="checkbox"/> TST READ: _____ MM DATE: _____ <input type="checkbox"/> QFT OUTCOME: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unreadable <input type="checkbox"/> Indeterminate <input type="checkbox"/> No Return		
_____ START TIME - (Ready for PHN)	_____ PROVIDER'S SIGNATURE	_____ SERVICE TIME (Minutes): (Time Spent with PHN)
		_____ CHECKOUT: (Front Desk)
INTERPRETER: _____ (Name/Number)		
_____ DATE:		

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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 relating to any and all immunizations received by my child/dependent at the FCHD with 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.)
81025	PREGNANCY TEST FP/MAT	90472	ADMIN FEE-ADDITIONAL	HSR	HOMELESS SHELTER RETURN
83655	LEAD SCREENING	90471	ADMIN FEE- INITIAL	IDC	INFANT DEVELOPMENT
84030	HEMOGLOBIN	MEDFORM	COMPLETION OF FORMS FOR COLLEGE ENTRY	MRX	MALARIA RX
86480	QUANTIFERON (IGRA) (circle) L or R	PAGE	COPYING CHARGE (1 ST 50 PAGES)	LDMRFEE	MEDICAL RECORDS SEARCH & HANDLING FEE
86706	HEPATITIS B SCREENING	PAGE50	COPYING CHARGE (AFTER 50 PAGES)	S0250	NURSING HOME SCREEN
86703	HIV TESTING	99403	INT CONSULTATION FEE (MD)	ODOT	OFFICE DIRECTLY OBSERVED THERAPY
		COU	COUNSELING STD/IMM/TB	99211	OFFICE VISIT
		DDW	DD WAIVER	PHA	PH ASSESSMENT
		99402	INT CONSULTATION FEE (RN)	RSO	RISK SCREEN
		HSI	HOMELESS SHELTER INITIAL		