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	MFG	Lot # /Expiration Date	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			
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	Z23				0.5 / IM			
90732		PNEUMOCOCCAL (POLYSACCHARIDE)	Z23				0.5 /IM			
90713		POLIO INJECTABLE	Z23				0.5 /IM			
90675		RABIES	Z23				1.0 /IM			
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:*** _____

☐ **TST READ:** _____**MM** **DATE:** _____ ☐ **QFT** **OUTCOME:** ☐ ***Positive*** ☐ ***Negative*** ☐ ***Unreadable*** ☐ ***Indeterminate*** ☐ ***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 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
86790	RABIES TITER	DDW	DD WAIVER	ODOT	OFFICE DIRECTLY OBSERVED THERAPY
		HSI	HOMELESS SHELTER INITIAL	PHA	PH ASSESSMENT
		HSR	HOMELESS SHELTER RETURN	RSO	RISK SCREEN
		IDC	INFANT DEVELOPMENT	90625	VAXCHORA (CHOLERA)