TB Only Form Packet

aitc IMMUNIZATION & TRAVEL CLINIC
SF DEPARTMENT of PUBLIC HEALTH

Adult Immunization & Travel Clinic
101 Grove Street, Room 102
San Francisco, CA 94102
ph (415) 554-2625 fx (415) 554-2619
www.sfdph.org/aitc

PLEASE PRINT CLEARLY

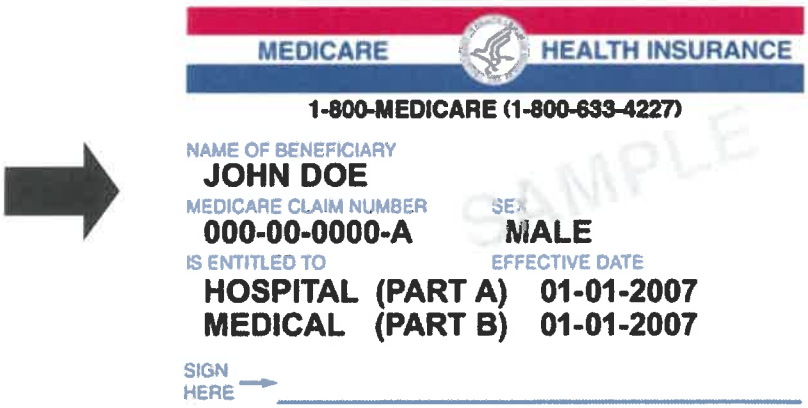
NAME _____

BIRTHDATE _____

SIGNATURE _____

TODAY'S DATE _____

The Medicare card (federal government issued health insurance) looks exactly like this



PLESE CHECK ONE:

☐ **NO**, I am **NOT** enrolled in any type of Medicare Plan

☐ **YES**, I have Medicare (read below)

Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

FOR STAFF ONLY:
☐ Contracts on file

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TO OUR VALUED **MEDICARE** CLIENTS:

- Our Medical Director and Nurse Practitioner have "opted out" of Medicare
- To receive services at AITC, please sign and date both of the attached Private Contracts, one with our Medical Director and one with our Nurse Practitioner
- This contract is with AITC Immunization & Travel Clinic only. It does not affect your Medicare benefits anywhere else
- Unfortunately, if you do not sign a Private Contract with AITC, we will not be able to provide services to you

What signing the Private Contract means:

- To receive services at AITC, you must pay out-of-pocket at our listed prices, even if those services would be covered elsewhere by Medicare
- Medicare will not pay for any services received at AITC
- You agree not to submit a claim to Medicare
- AITC will not bill Medicare for you
- You are not required to sign a Private Contract with AITC. You are free to seek Medicare services elsewhere from a practitioner that has not opted-out

- THANK YOU FOR YOUR UNDERSTANDING

Client Registration Form

(Please Print Clearly)

IMMUNIZATION & TRAVEL CLINIC
SF DEPARTMENT of PUBLIC HEALTH

Last Name

First Name **M.I**

Birthdate M M D D Y Y

Race
- ☐ African-Amer.
- ☐ American Indian (Native)
- ☐ Asian
- ☐ Other
- ☐ Pacific Islander
- ☐ White

What was your sex at birth?
☐ Male ☐ Female

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non Hispanic
- ☐ Unknown

What is your gender identity?
- ☐ Male ☐ Female
- ☐ Trans Male ☐ Trans Female
- ☐ Genderqueer / Gender non-binary
- ☐ If Not Listed, please specify below

ONLY FOR 18 AND OLDER: How do you describe your sexual orientation or sexual identity?
- ☐ Bisexual
- ☐ Gay/Lesbian/Same-gender loving
- ☐ Straight/Heterosexual
- ☐ Questioning/Unsure
- ☐ Not listed: _____
- ☐ Decline to state

Email Address

PHONE: CELL ( ) _____-_____ ☐HOME ☐OFFICE : ( ) _____-_____

MAILING ADDRESS _____
APT# City State Zip

OCCUPATION: _____ **EMPLOYER/SCHOOL:** _____

EMERGENCY CONTACT _____
Name Relationship Phone

HOW DID YOU LEARN ABOUT AITC: (CHECK ALL THAT APPLY)

☐ I am an established client of AITC ☐ Web Search ☐ Yelp ☐ Referral by my friend/family/school/ work ☐ Other _____

☐ Referral by my doctor/clinic (name, phone) _____

Consent for Medical Care and Payment Responsibility

(1) I, as the client/patient, agree to receive care from a health care Provider at the Adult Immunization & Travel Clinic ("AITC"), San Francisco Department of Public Health ("DPH"). I give consent for examination, immunization, blood or skin testing, medical advice, and other services from my AITC Provider.

(2) If my AITC Provider prescribes a drug, I understand that AITC can transmit the prescription to a pharmacy of my choice; or, if I purchase the drug from AITC, I understand that the drug is not returnable and that insurance may not reimburse the cost.

(3) I have reviewed the information about privacy practices and disclosures on the reverse side of this form.

(4) I understand that AITC is not a Medicare provider.

(5) I understand and agree that: (a) it is my responsibility to pay the charges in full for all services rendered; (b) I authorize my insurance company to pay directly to AITC any benefits due under the terms of my health care plan for services provided by AITC; (c) AITC reserves the right to refuse assignment of medical benefits; and (d) if my insurance company does not pay the charges in full, it is my responsibility to pay the entire full balance for all services rendered by AITC.

Signed: _____ **Date:** _____

If client is a minor:

Print name of parent/ guardian: _____

Signature of parent/guardian: _____ Date: _____

SFDPH SUMMARY NOTICE OF HIPAA PRIVACY PRACTICES

Full Notice: You have been provided the Full Notice of HIPAA Privacy Practices. Please read it carefully. You can also find it at: https://www.sfdph.org/dph/comupg/oservices/medSvs/HIPAA/HIPAASummaries.asp.

Who will follow the rules in this notice: All DPH and contract provider employees, DPH affiliates, as well as staff assigned to DPH by the University of California at San Francisco, must follow these rules.

You have the right to: (Please see possible restrictions in the "Full Notice of Privacy Practices".)

- Ask to see, read and/or obtain a copy of your health record (charges may be necessary).
- Ask to correct information that you believe is wrong in your health record.
- Ask that your health information not be shared with certain individuals.
- Ask that your health information not be used for certain purposes; for example, research.
- Ask that copies of your health record be sent to someone (charges may be necessary).
- Be informed about who has read your record (for reasons other than treatment, payment and program improvement purposes).
- Specify where and how DPH employees may contact you.

DPH may use and disclose your health information to improve your treatment.

- To improve the quality of care you receive, health information may be shared between treatment providers, including your health information regarding mental health, substance abuse, HIV/AIDS, sexually transmitted diseases (STD), and developmental disabilities.
- There are circumstances when health information about you will not be shared unless you first give your permission for it to be shared; such as services received in substance abuse treatment agencies.

If you believe your privacy rights have NOT been maintained while receiving DPH services, you may file a complaint. If you have concerns about how your health information might be (or has been) shared, please speak with your provider or contact either of the following: (1) Secretary of U.S. Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, San Francisco, CA 94103. (2) DPH Office of Compliance and Privacy Affairs, 101 Grove St., Room 330, San Francisco, CA 94102, or call toll-free 1-855-729-6040. You will not be penalized in any way for filing a complaint.

By your signature on the reverse side of this page, you:

- Acknowledge receipt of the San Francisco Department of Public Health "Full Notice of HIPAA Privacy Practices."
- Agree that if the DPH services you received at AITC are to be billed to a third party health insurance, then you authorize the release to the insurer, the claims processor, and their intermediaries, of any medical and other information necessary to process the claim.

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TB SCREENING FORM

NAME: _____ BIRTHDATE: _____

⇨ TELL US THE REASON(S) FOR YOUR TB SCREENING TODAY (CHECK ALL THAT APPLY)

☐ I need a TB test for work or school. *(employer or school):* _____

☐ Other reason: _____

⇨ PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Yes ☐No **Were you born or raised outside the USA?**

If Yes ⇨ Country of Birth _____

Year entered the USA _____

Received BCG* vaccine? ☐Yes ☐No

Year of last BCG _____ ☐N/A

** BCG = a TB vaccine given in some countries (but not in the USA)*

_____ **Date of Most Recent TB Test**

day / mo / yr Type of test ☐Skin test

☐Never had ☐Blood (Quantiferon)

☐Don't know

☐Yes ☐No **Ever had a Positive** TB test?**

If Yes ⇨ Year of Positive TB test _____

Type of test ☐Skin test

☐Blood (Quantiferon)

*** Positive TB Skin Test = Raised bump at test site; told by health care professional it was TB positive, usually requires a Chest X-Ray.*

☐Yes ☐No **Ever had a Chest X-Ray for TB?**

If Yes ⇨ Year of Chest X-Ray _____

Result ☐Active TB

☐Not Active TB

☐Yes ☐No **Ever taken INH (Isoniazid) for TB?**

If Yes ⇨ Year you took INH _____

Number of months taken _____

I certify that the information I have provided is true to the best of my knowledge. I will not hold this clinic or its staff responsible for any errors or omissions I may have made in completing this form.

Client Signature _____ ***Date*** _____

☐Yes ☐No Take any medications?

If yes, list:

☐Yes ☐No Have any medical conditions?

If yes, list:

☐Yes ☐No Have a condition or take a medicine that weakens the immune system?

☐Yes ☐No Currently pregnant?

☐Yes ☐No Faint or get lightheaded with needles?

☐Yes ☐No Allergic to medications or vaccines?

If yes, list:

Have you ever:

☐Yes ☐No Been sick with, or treated for TB?

☐Yes ☐No Had contact with, or lived with someone sick with active TB?

☐Yes ☐No Lived or worked in a refugee camp, homeless shelter or jail?

☐Yes ☐No Been a health care worker?

☐Yes ☐No Traveled to the developing world and had close contact with the local population? *If yes, describe:*

Do you have these symptoms?

☐Yes ☐No Cough lasting more than 3 weeks?

☐Yes ☐No Coughing up blood?

☐Yes ☐No Unintentional weight loss?

☐Yes ☐No Loss of appetite?

☐Yes ☐No Fever?

☐Yes ☐No Sweating at night?

⇨ AITC STAFF USE ONLY

TEST: ☐ 1-Step TST ☐ 2-Step TST ☐ QFT-IT Gold

☐ Symptom Review Only (skip to p. 2) ⟶

Step	Date Placed	Site	Lot #	Placed By	Date Read	Result	Read By
#1	_____	R L	_____	_____	_____	____ mm	_____
#2	_____	R L	_____	_____	_____	____ mm	_____

ASSESSMENT:

☐ Pos ☐ Neg State TB Risk Assessment

☐ Yes ☐ No AITC TB Risk Factor(s)

☐ Yes ☐ No AITC TB Symptoms

☐ Pos ☐ Neg ☐ Ind TST Step #1

☐ Pos ☐ Neg TST Step #2

☐ Pos ☐ Neg ☐ Ind QFT-IT Gold

PLAN:

☐ State Certificate Completed ☐ Yellow Card w/Result ☐ TB-47 Given

☐ CXR Referral Form ☐ Education per Protocol

☐ Other Referral To: _____ For: _____

Clinician Signature: _____ Date: _____

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TB SCREENING FORM - continued

History of LTBI

⇨ AITC STAFF USE ONLY

TB Testing (list dates, test types, findings) _____

_____

CXR (list dates, findings, esp. most recent CXR) _____

_____

Sx Review ☐ Positive for Sx ☐ Negative for Sx

LTBI Tx ☐ Treated: Completion Documented → *(Attach Copy of Documentation)*
☐ Incomplete: Not completed, Not Documented, or Documentation Unavailable
☐ Not Treated

Congregate	☐ Yes ☐ No	Employee or resident of Congregate Living setting (jail, shelter, SNF, rehab, etc)
Exposure	☐ Yes ☐ No	Recent (since last TB eval) exposure to Active TB Case
Risk Factors	☐ Yes ☐ No	HIV or other significant immune compromise due to illness or medication
	☐ Yes ☐ No	TB test conversion within past 2 years
	☐ Yes ☐ No	On immune modulator therapy for autoimmune disease
	☐ Yes ☐ No	End Stage Renal Disease, silicosis, jejuno-ileal bypass, or head/neck carcinoma
	☐ Yes ☐ No	Old inactive TB on prior CXR
	☐ Yes ☐ No	Diabetes, gastrectomy, IV drug use, or malnutrition

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DISPOSITION / PLAN

☐ **(A)** No F/U needed unless new TB exposure or Sx develop

☐ **(B)** Return annually for Sx Review — get CXR whenever symptomatic

☐ **(C)** CXR / PCP Visit now to evaluate for TB reactivation. (If NEG, return for annual Sx review.)

☐ **(D)** CXR now to evaluate for TB reactivation; Plus Sx Review every 3 mos, CXR every 6 mos

☐ **(E)** CXR now to evaluate for TB reactivation; Plus CXR & Sx Review every 6 mos x 2 years

☐ **(F)** CXR now to evaluate for TB reactivation; Plus Sx Review every 6 mos, CXR annually

☐ **(G)** CXR now to evaluate for TB reactivation; Plus CXR & Sx Review annually

Referral To: _____

Clinician Signature: _____ Date: _____