TB Risk Assessment for Outreach Events

CAMPUS HEALTH CENTER
5200 Anthony Wayne Drive, Suite 115, Detroit, MI 48202 | (313) 577-5041

Name: _____ **DOB:** _____ **Age:** _____ **Sex**: *(circle)* Male Female Transgender Undefined

Primary USA Mailing Address: _____
Street *Apt/Box #*

☐ **Home**
☐ **Campus/Local** _____ _____
☐ **Other:** *City* *State* *Zip Code* *Banner ID*

Primary Phone: _____ ☐ Home ☐ Cell ☐ Work **WSU Access Id Email:**

Insurance Name: _____ **ID Number:** _____**Group #:** _____

Subscriber Name: _____**Date of Birth:** _____ **Relationship to** ☐ Self ☐ Spouse
Subscriber: ☐ Parent/Child

I authorize and consent to medical, diagnostic, therapeutic, and other procedures and treatment by the physicians, physician assistants, nurse practitioners and other staff at Nursing Practice Corporation, a Michigan non-profit corporation doing business as Campus Health Center ("Center"). I understand the risks of the medical treatment and procedures, and that the practice of medicine is not an exact science. No guarantees or promises have been made concerning the outcome of any procedures or treatment. I understand that I have the right to make decisions concerning my health care, including my right to refuse medical and surgical procedures. I understand that if any agent or employee of the Center AT ANY TIME sustains a percutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound or other significant exposure to my blood or other bodily fluids, I may be tested for HIV (the virus that causes AIDS), Hepatitis B, Hepatitis C, and/or Syphilis, and I consent to such tests. Any changes in this consent must be initialed by the patient and a member of the Center staff and may result in the reduction of services.

SIGNATURE: _____ **DATE**: _____
(Parent or guardian must sign if patient is under 18, incompetent, disoriented or mentally unstable) *MM / DD / YY*

I have received and reviewed the Center's *Notice of Privacy Practices* that contains more detailed information about how, why and when the Center may use and disclose Protected Health Information ("PHI"), as defined by HIPAA. I acknowledge that the Center may, from time to time, change its privacy practices and agree that Center may use and disclose my PHI in accordance with its *Notice of Privacy Practices*.

SIGNATURE: _____ **DATE**: _____
(Parent or guardian must sign if patient is under 18, incompetent, disoriented or mentally unstable) *MM / DD / YY*

I certify that all information provided by me on this form is true and correct, that I fully understand the consents and authorizations given above, that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily, and that I am the Patient listed in this document or I am duly authorized by the Patient listed in this document to provide the consents and authorizations described herein and to sign this document. I hereby assign to the Center all rights to insurance payment for professional services provided by it. This assignment will remain in effect until it is revoked in writing by Patient or a person authorized to revoke it on Patient's behalf. A photocopy of this assignment is to be considered as valid as the original. I agree to pay to the Center for charges resulting from services rendered that are not covered by insurance or other third party payment. I agree all bills are due in full at the time of service. Should I fail to honor these obligations, I agree to pay any collection costs and attorney fees resulting from collection of my accounts.

SIGNATURE: _____ **DATE**: _____
(Parent or guardian must sign if patient is under 18, incompetent, disoriented or mentally unstable) *MM / DD / YY*

Reg Complete:

Yes	No	
☐	☐	Have you ever had a positive TB skin test? If yes, were you treated with medication? ☐ No ☐ Yes How long? _____ Past record provided? ☐ No ☐ Yes
☐	☐	Have you ever been vaccinated with BCG (TB vaccine)? If yes, when? _____
☐	☐	Have you had any of these symptoms? *(check all that apply)* ☐ Cough for longer than 3 weeks ☐ Chronic fever ☐ Unexplained weight loss ☐ Coughing up blood or blood in sputum ☐ Night sweats for longer than 3 weeks
☐	☐	Have you had recent close contact with someone with infectious TB disease (family, co-worker, roommate, etc.)?
☐	☐	Have you ever lived with someone who has had a positive PPD test?
☐	☐	Have you ever had an abnormal chest x-ray?
☐	☐	Have you tested positive for HIV or AIDS?
☐	☐	Have you ever had an organ and/or bone marrow transplant?
☐	☐	Have you ever taken medications that affect your immune system?
☐	☐	Have you spent 30 or more consecutive days in a country other than the United States? If yes, where and when? Country: _____ Year: _____
☐	☐	Do you live or work in any of the following settings**: (***check all that apply)* ☐ Long term facility ☐ Correctional facility (prison) ☐Correctional facility (prison) ☐ Hospital ☐ HIV/AIDS residence ☐ Laboratory (specify type): ☐ Other health care facility ☐ Homeless shelter

Internal Use Only			Tubersol	Lot #	Placement: Left	Provider Initial:	Chart Complete:
PPD	IGRA	CXR	Exp:	Sanofi Pasteur	Right		