Solicitation 12108-10

Electronic Medical Records System

Collin County

Bid 12108-10
Electronic Medical Records System

Bid Number	12108-10
Bid Title	Electronic Medical Records System
Bid Start Date	In Held
Bid End Date	Jul 8, 2010 2:00:00 PM CDT
Question & Answer End Date	Jul 2, 2010 5:00:00 PM CDT
Bid Contact	Leslie Harper Contract Administrator Collin County Purchasing 972-548-4122 lharper@co.collin.tx.us
Contract Duration	1 year
Contract Renewal	Not Applicable
Prices Good for	90 days
Pre-Bid Conference	Jun 18, 2010 10:00:00 AM CDT Attendance is optional Location: Collin County Commissioner's Courtroom 2300 Bloomdale Road, 4th Floor McKinney, TX 75071
Standard Disclaimer	***Note to Bidders/Offerors~The following standard disclaimer applies to Invitation to Bid (IFB), Competitive Sealed Proposal (CSP), and Request for Proposal (RFP) ONLY, not applicable to Request for Qualifications (RFQ) or Request for Information (RFI).*** Prices bid/proposed shall only be considered if they are provided in the appropriate space(s) on the Collin County bid form(s). For consideration, any additions or deductions to the bid/proposal prices offered must be shown under the exceptions section of the bid/proposal in the case of electronic submittal, ONLY in the case of a hard copy submittal will an additional attachment be allowed. Extraneous numbers, prices, comments, etc. or bidder/offeror generated documents appearing elsewhere on the bid or as an additional attachment shall be deemed to have no effect on the prices offered in the designated locations. All delivery and freight charges (F.O.B. inside delivery at Collin County designated locations) are to be included as part of the bid/quote/proposal price. All components required to render the item complete, installed and operational shall be included in the total bid/quote/proposal price. Collin County will pay no additional freight/delivery/installation/setup fees.

Item Response Form

Item	12108-10-1-01 - Electronic Medical Record System
Quantity	1 each
Unit Price	
Delivery Location	Collin County 3631 Health Care/WIC

825 N. McDonald St. Ste 120
McKinney TX 75069
Qty 1

Description

Collin County seeks proposals leading to the selection of an Electronic Medical Records System that will best meet the clinical and management information needs of the Collin County Health Care Services employee health clinic and the public health clinics.

COLLIN COUNTY, TEXAS

REQUEST FOR PROPOSAL

SUBMIT PROPOSALS TO:

Office of the Purchasing Agent
Collin County Administration Building
2300 Bloomdale, Suite 3160
McKinney, TX 75071

****NOTE:**
All correspondence must include suite number to assist in proper delivery.**

SUBMIT NO LATER THAN:

2:00 P.M., Thursday, July 8, 2010

MARK ENVELOPE:

RFP No. 12108-10

ELECTRONIC HEALTH RECORDS SYSTEM

ALL PROPOSALS MUST BE RECEIVED IN THE OFFICE OF THE PURCHASING AGENT BEFORE RECEIVING DATE AND TIME

Public receipt of proposals is scheduled to be held in the Office of the Purchasing Agent, Collin County Administration Building, 2300 Bloomdale, Suite 3160, McKinney, Texas 75071.

If offeror does not wish to submit an offer at this time, please submit a "NO OFFER" by the same time and at the same location as stated above and state the reasons for such.

Awards should be made not more than one hundred and eighty (180) days after receiving date.

Collin County is always conscious and extremely appreciative of your time and effort in the preparing of this offer. Requests for information should be directed to:

Leslie Harper
Contract Administrator
Collin County Administration Building
2300 Bloomdale, Suite 3160
McKinney, Texas 75071
E-Mail: lharper@co.collin.tx.us
Telephone: 972/548-4122 or;
Dallas Metro: 972/424-1460 ext. 4122
Facsimile: 972/548-4694

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Part 1 General Information

1.1 Introduction

Collin County, Texas (hereafter referred to as the "County") seeks proposals to implement an Electronic Medical Records System (EMRS) system for County Healthcare Services and associated clinics. As the population of Collin County continues to grow, the EMRS is a step towards enhancing the efficiency of the services we provide to the public, as well maximizing available staff work hours by streamlining certain tasks, or automating them entirely. The impact of having this EMRS is far reaching. Since we are the sole source of care for Tuberculosis patients in Collin County, we, in many ways, have technological needs similar to a private medical specialist's practice.

The proposed integrated Electronic Medical Records System (EMRS) system will

- assure immediate access to vital patient information by caregivers regardless of which of the clinics is delivering care
- assure that patient medical records in electronic form are not vulnerable to destruction like paper records and can continue to be accessed immediately even though a patient may be displaced by disaster
- enhance transparency in cost and treatment quality measures so that patients can make more informed decisions about where they seek their medical care
- provide a sound investment that will promote quality of care including improved management of chronic diseases

1.2 County Background

1.2.1 Demographics

Collin County, Texas occupies approximately 886 square miles just northeast of Dallas. Collin County is one of the fastest growing counties in the nation and currently has a population in excess of 760,000 citizens. The County has a total combined budget total for all funds of $270 million[1]. The annual operating budget is $175 million[2] from the general revenue fund.

1.2.2 Funding

The fiscal year for the County runs from October 1st through September 30th. Funding for this project has been allocated by the Commissioners' Court. Funds for payment of maintenance and operations line items are provided through the County budget approved for the current fiscal year only. State of Texas statutes prohibit the County from any obligation of public funds beyond the fiscal year for which a budget has been approved. Anticipated orders or other obligations that arise past the end of the current County fiscal year shall be subject to budget approval. Ongoing contractual obligations, such as maintenance and support agreements, must comply with the County's fiscal year constraints. By submission of a response to this request for proposal, Offerors agree to follow the county fiscal year restrictions for ongoing contractual obligations.

1.2.3 Governance

The County's governing body, Commissioner's Court, is made up of the County Judge who is elected at large and four Commissioners elected from equal precincts. The County Judge is the

[1] Collin County FY2010 Budget In Brief
[2] Collin County FY2010 Budget In Brief

presiding officer of the Commissioners Court. Commissioner's Court provides general direction for the county and establishes the yearly budget.

This project will report to a governing body, working under the oversight of the Commissioner's Court. Project status and updates may be periodically required by Commissioner's Court during routine Commissioner Court sessions. The governing body for this project will be an evaluation committee which consists of the County Department Heads and Appointed Officials who manage and direct the departments that will be using the selected system on a daily basis. The evaluation committee will provide general oversight of their respective areas but will have daily involvement at the implementation level. The evaluation committee will ratify business process changes, proposed by the project team, which may be necessitated by the implementation of the selected system[3]. Any changes which involve a change in the timeline or the cost of the implementation must be submitted to the evaluation committee. If the evaluation committee accepts the change then it must be submitted to Commissioner Court for acceptance.

The evaluation committee will provide general guidance and oversight to the project team. The project team will be led by a Collin County project manager who will lead a cross functional team of county subject experts during the implementation. The county implementation team will be tasked with acquiring additional, short term, subject experts for specific job knowledge as the implementation progresses. The project team will be responsible for routine day to day decisions that will be required during the implementation phase of the project.

1.2.4 Basis for Action

Selected provider and systems implemented shall comply with regulations as defined by The United States Department Of Health and Human Services, Office of The Secretary, 45 CFR Part 170, RIN 0991–AB58, Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology.

1.2.5 Key Success Criteria

The key success indicators for this project include:

Collin County will evaluate the responses to this RFP based on the vendor's ability to:

- Meet the functional and technical requirements described in this RFP as evidenced by the RFP response and demonstration of the software.
- Provide a cost-effective solution that meets the financial goals of Collin County Health Care Department.
- Provide timely program modifications and upgrades in response to changing industry needs, regulatory requirements, and advancing technology.
- Demonstrate expertise and functionality as evidenced by client references and site visits.
- Provide a superior level of customer service and technical support, both pre-installation and post-installation to clients as evidenced by references.

[3] Some business process changes will require the passage of a Commissioner Court order.

1.3 Project Scope and Time Line

The scope of this project is to implement a comprehensive Electronic Health Records System for Collin County Health Care Services (CCHCS). At this time, we envision implementing modules progressively to address the needs of direct patient care and internal workflows of five separate CCHCS clinics/departments. All CCHCS staff members use Microsoft tools such as MS Outlook, MS Word, MS Excel, MS Access, and MS Publisher to varying degrees. The clinic services and auxiliary applications currently used are outlined below:

CLINIC/ DEPARTMENT	SERVICES	CURRENT AUXILLIARY APPLICATIONS USED
Employee /Occupational Health Clinic	Provides primary care services to Collin County employees and their dependents, new employee physicals, and drug screenings	
Immunizations Clinic	Provides a variety immunizations to children and adults	TWICES (Texas Wide Integrated Clinic Encounter System) AS400 (registration process)
Tuberculosis Clinic	Provides screening, diagnostic, case investigations, and treatment services for active and latent tuberculosis infections to Collin County residents	TWICES (Texas Wide Integrated Clinic Encounter System) AS400 (registration process)
STD/Komen Clinic	Provides testing, screening, education, and counseling services related to sexually transmitted diseases (STD); the Komen Program provides breast exams and referral services related to breast cancer screenings to medically underserved and/or underinsured women	AS400 (registration process)
Epidemiology	Team collects reports of infectious disease, performs active surveillance of communicable diseases, conducts case investigations from disease reports, issues alerts and notifications to state and local agencies, and provides information and guidance to the medical community, schools, and other organizations with regards to reporting and controlling the spread of communicable diseases.	NEDSS (National Electronic Disease Surveillance System) PHIN (Public Health Information Network)

The County desires to implement a “vanilla” version of the selected Electronic Medical Records System with no customizations or modifications made to meet the business requirements identified in Attachment A. The county is considering software implementations in either a traditional software license model <u>or</u> a hosted application. The cost sheet should contain alternate pricing options for both a hosted and traditional software purchase, if both are offered by the firm. The County further requires that the system be architected such that a data element would only be entered once in the application and then referenced throughout other application modules. The County understands that some amount of modification may be necessary however, in order to meet the unique needs of Collin County. Any required modification must be completed using development processes that will not require the modification to be re-developed during any patch or system upgrade. The selected system must be developed such that the County, as a

customer, may perform all required system maintenance without the need to engage the Offeror for routine support or during patch and system updates; if the software is installed on county systems. Furthermore, should the software be installed on county systems, the County will have access to utilize the software development toolkit or development framework used to create the software to extend or customize the function of the software to match future County business processes without requiring the modification of any system source code.

The county proposes the following high level timeframe to accomplish the system implementation:

June 8, 2010	Release RFP
June 18, 2010	Pre-Proposal Conference, 10:00 a.m.(see 1.4.17)
July 8, 2010	Receive RFP responses
July 12, 2010	Distribute responses to Evaluation Committee
July 30, 2010	Select and notify vendors for on-site demo
August 9, 2010	Begin demo process
August 20, 2010	Best and Final Offers Due
September 3, 2010	System selection
September 10, 2010	Complete contract process
September 20 2010	Commissioner Court Award
October 1, 2010	Implementation Start
November 15, 2010	Integration testing & user training
November 30, 2010	Configuration freeze
January 1, 2011	Go Live

Note: These dates may be subject to modification at the County's discretion.

1.4 Guidelines

By virtue of submitting a proposal, interested parties are acknowledging:

1.4.1 Offerors to this proposal must provide return on investment (ROI) documentation for the proposed solution which will detail cost benefits to the County on the basis of detailed process efficiencies, reduced technical and functional staffing increases over a five (5) year period, staffing savings historically gained in implementations of the same size and complexity as the County and any other key indicators deemed pertinent, by the Offeror, for the specific solution.

The County seeks to optimize ROI opportunities within this project and reduce the overall operating costs of the County over the next five fiscal years. Through the use of best practice methodologies, process improvements and other cost reduction opportunities the County anticipates that the overall general operating costs of the county will be reduced after the system is in a live productive environment.

1.4.2 This RFP is a request for the acquisition and implementation of an Electronic Medical Records System which may require turn-key implementation services. As such, proposals from firms without an implementation mechanism will not be considered.

1.4.3 The structure of the bidding process is as follows: *(1) Software firms partnering with an Implementation firm will be the lead Offeror during the RFP process and the County will coordinate communication through the Software firm point of contact only; (2) Firms offering Implementation Services only may only be represented in one proposal; (3) Third-Party firms may exist in more than one proposal but any communication during the RFP process will be directed through the Software firm point of contact.*

1.4.4 If a software solution firm and an implementation services firm partner together to respond to this RFP then the Software firm will be considered the primary point of contact for the selection process. However, the County may sign joint or separate licensing and implementation services agreements. The County reserves the right to use this RFP to choose a software solution firm only and later release a different RFP to select implementation and consulting services.

1.4.5 The County will have the right to review the resumes of any consultants proposed to work on this project and provide either an acceptance or rejection of the resource. The Offeror agrees to submit to the County the proposed consultant information and the County will have 5 business days to provide notification to the Offeror. Should the County not be able to verify the background of the proposed consultant, the County Project Manager will notify the Offeror Project Manager of the deficiency and may request additional time for the acceptance process. By virtue of submitting a proposal response, the Offeror understands that the County will require criminal background history checks to be performed prior to any Offeror resource gaining access to our financial and computer systems. The background checks will be performed by the Collin County Sheriff Office.

Offeror personnel proposed for the Project Manager position should be PMP certificate holders and be familiar with ITIL process methods.

1.4.6 The County reserves the right to reject any or all proposals if it determines that select proposals are not responsive to the RFP. The County reserves the right to reconsider any proposal submitted at any phase of the procurement. It also reserves the right to meet with select Offerors at any time to gather additional information. Furthermore, the County reserves the right to delete or add functionality up until the final contract signing.

1.4.7 All third party software solutions proposed as part of this package are subject to the same guidelines of this RFP, unless otherwise stated. The cost of any third party products shall be included in the costing sheets required as part of the RFP response.

1.4.8 This procurement involves negotiated contracts. It is anticipated that, after the County elevates firms after product demonstrations and other evaluative processes, negotiations will take place on costs as well as other items that mitigate the County's risk. The County will consider all costs and business terms to be negotiable and not artificially constrained by internal corporate policies. Firms that contend that they lack flexibility because of their corporate policy on a particular negotiation item will face a significant disadvantage and may not be elevated to the final negotiation phase. The County reserves the right to proceed directly to contract negotiations if a single software and services proposal is deemed to be in the best interests of the County.

1.4.9 When separate software product and implementation services are proposed, the County expects to enter into a software licensing agreement (or hardware acquisition) with the product provider and an implementation services agreement with an implementation firm. If the County is not satisfied with the qualifications, cost, or experience of the implementation firm or any third-party solution, as part of this RFP process, it reserves the right to request that the Software firm provide another implementation partner or serve as the prime contractor for the implementation. Although the County may enter into separate agreements with the Software and Implementation firms the County expects that the Software firm will have some roll in the implementation process and that both parties will be responsible for the successful implementation of the solution. All firms submitting proposals, by virtue of doing so, are recognizing that the County retains this option.

1.4.10 The County requires that licenses for software be "perpetual" (i.e., the County purchases and retains the license to use the software forever) and of a "fixed" price

nature (i.e., license fees, maintenance, and support cost schedule for first five years are presented). Maintenance and support costs should be fixed at a set amount, based on the final negotiated purchase price, and should not be tied to an escalating percentage. The set maintenance and support rates should remain in effect as long as the County remains current, within two patch releases, on software versions. Furthermore, Offerors shall provide a "not-to-exceed" maintenance schedule for Years 6-10 (e.g., 2% escalator per year).

1.4.11 Proposals on implementation services are expected to be on a **fixed cost basis.** Offerors are to provide all work effort needed to meet the detailed functional requirements as part of their offer/proposal. ***All firms submitting proposals are encouraged to submit the most competitive proposal possible, as the failure to do so may lead to elimination prior to software demonstrations***. All payments are to be based on milestone deliverables within the Offeror's proposed project plan.

1.4.12 Proposals shall include all modules that the County needs to attain the functionality stated in the detailed functional requirements spreadsheets in this RFP. Furthermore, all consulting hours needed to deliver the functional requirements, including work effort related to customization, configuration, interfaces, data conversion, and reporting, shall be included in the cost proposal for comparison purposes. When responding to the business requirements documented in Attachment A, Offerors are advised that some requirements may appear to be duplicated but must be answered as an independent item. Some requirements may deal with the accounting practices specific to a functional area. However, any functional requirements in Attachment A identified as "future requirement" should be priced as a separate line item in the implementation services cost proposal.

1.4.13 All firms submitting proposals agree that their pricing is valid for a minimum of one hundred and eighty (180) days after proposal submission to the County. Furthermore, the County is, by statute, exempt from the State Sales Tax and Federal Excise Tax; therefore, proposal prices shall not include taxes.

1.4.14 While the County has used considerable efforts to ensure accurate representation of the information of this Request for Proposal, the information contained in this request is supplied as minimum requirements for offerors. The information is not guaranteed or warranted to be accurate by the County nor is it necessarily comprehensive or exhaustive. Nothing in the Request for Proposal is intended to relieve the Offerors from forming their own assumptions and conclusions with respect to the matters addressed in this request. When responding to the detailed business requirements, Attachment A, the Offeror must identify the assumptions used to respond to that specific requirement. The Offeror must also fully answer each business requirement, even if it seems to be a duplicate of a previously stated requirement, as each requirement may be given from a specific point of view. Failure to do so may result in the proposal response not being elevated to the next evaluation phase.

1.4.15 This RFP does not commit the County to award nor does it constitute an offer of employment or a contract for services. Costs incurred in the submission of this proposal, or in making necessary studies or designs for the preparation thereof, are the sole responsibility of the Offerors. Further, no reimbursable cost may be incurred in the anticipation of award. Proposals containing elaborate artwork, expensive paper and binding, expensive visual or other presentations are neither necessary nor desired.

1.4.16 In an effort to maintain fairness in the process, all inquiries concerning this procurement are to be directed only to the County's Purchasing Department in writing. Proposers will refrain from contact from any member of the Commissioners' Court, project governing committee or any other County employee to influence the procurement decision.

The point of contact for this RFP is:

Leslie Harper
Contract Administrator
Collin County Administration Building
2300 Bloomdale, Suite 3160
McKinney, Texas 75071
P: (972) 548-4122
F: (972) 548-4694
E-Mail: lharper@collincountytx.gov

When responding to this RFP, follow all instructions carefully. Submit proposal contents according to the outline specified and submit all hard copy and electronic documents according to the instructions. Failure to follow these instructions may be considered a nonresponsive proposal and may result in immediate elimination from further consideration.

1.4.17 Pre-Proposal Conference: A Pre-Proposal conference will be held at 10:00 a.m. on June 18, 2010 at the Collin County Commissioners' Courtroom located at 2300 Bloomdale, 4th Floor, McKinney, TX 75071. All prospective offerors are requested to have a representative present. It is the offeror's responsibility to review the site and documents to gain a full understanding of the requirements of the RFP. Prospective offerors may attend the pre-proposal conference via conference call. Please call 972-547-1833 at the date and time listed above.

Part 2 Detailed Submittal Requirements

2.1 General Requirement

In order to facilitate the analysis and evaluation of responses to this RFP, Offerors are required to prepare their proposals in accordance with the instructions outlined in this part. Proposals should be prepared as simply as possible and provide a straightforward, concise description of the Offeror's capabilities to satisfy the requirements of the RFP. Emphasis should be concentrated on accuracy, completeness, and clarity of content. All parts, pages, figures, and tables should be numbered and clearly labeled. Documents shall be submitted using Microsoft Office tools and must be saved in Office 97-2003 format in order to ensure backward compatibility.

Offerors are required to follow the outline below when preparing their proposals:

Section	Title
	Title Page
	Letter of Transmittal
	Table of Contents
1.0	Executive Summary
2.0	Scope of Services
3.0	Company Background
4.0	Proposed Application Software and Computing Environment
5.0	Third-Party Products
6.0	Implementation Plan
7.0	Training
8.0	Maintenance and Support Programs
9.0	Essay Responses
10.0	Responses to Functional/Technical Requirements
11.0	Client References
12.0	Cost Proposal
13.0	Exceptions to the RFP
14.0	Sample Documents

Instructions relative to each part of the response to this RFP are defined in the remainder of this section.

2.2 Executive Summary (Section 1.0)

This part of the response to the RFP should be limited to a brief narrative, approximately one page, highlighting the Offeror's proposal. The summary should contain as little technical jargon as possible and should be oriented toward non-technical personnel. This section should not include cost quotations. Note that the executive summary should identify the primary contacts for all Offerors, including Third Party firms. The signature page, refer to Attachment G, should be included at the end of this section.

2.3 Scope of Services (Section 2.0)

This section of the proposal shall include a general discussion of the Offeror's understanding of the "overall" project and a summary of the products and services being proposed. Offerors should include a summary narrative of the data conversion process and the interfaces to other County owned systems in this section.

2.4 Company Background (Section 3.0)

The Offeror shall provide the following company background information so that the County can evaluate the corporate stability and Offeror's ability to support the commitments set forth in response to the RFP. The County, at its option, may require an Offeror to provide additional support and/or clarify requested information.

- Amount of time the company has been in business.
- A brief description of the company size and organizational structure.
- Amount of time and what experience Offeror has in the public sector, particularly public sector clients of similar size and complexity to the County.
    - Texas clients should be highlighted
- Most recent audited financial statements.
- List of "live" public sector customer installs by name and by state. (Texas customers, preferably Counties, are to be listed first) The number of users should also be included.
- Any material (including letters of support or endorsement from clients) indicative of the Offeror's capabilities.
- If partnering with other firms, the amount of time the partner firm has worked with the Offeror and how many implementations the two parties have completed together.
- Evaluations of the software and/or services firm by industry analysts.
- List of any terminated public sector projects. Disclose the jurisdiction and explain the termination.
- List of all law suits resulting in award (in or outside of court) to a client and provide basis and finding of any settlement.

2.5 Proposed Application Software and Computing Environment (Section 4.0)

In addition to providing an overview of the solution proposed for the County, the Offeror shall present, in detail, the key features and capabilities of the proposed solution as they relate to the County. In addition to the description, provide in succinct narrative form (at least one paragraph per item) answers to the following questions (if a question is not pertinent to the proposed solution please respond as Not Applicable):

2.5.1. Technology Architecture. The County has extensive technology architecture in place and follows an Enterprise Architecture process to ensure our ability to support items added to our architecture. Describe the optimal network and system requirements for the proposed solution. In the event that there is more than one suitable network configuration, list all options, including the relative strengths and weaknesses (if any) of each. What are the optimal database requirements? In the event there is more than one suitable platform, list all options, indicating the relative strengths and drawbacks (if any) of each. What are the ideal server requirements? What are the ideal desktop (client) requirements? In the event there is more than one suitable operating system, list all options indicating the relative strengths and drawbacks (if any) of each.

This section shall include architecture drawings, submitted in MS Visio format, of the technology architecture. These drawings should show the optimal configuration desired by the Offeror for the proposed solution.

The Offeror should identify in this section how the proposed solution may be deployed within a virtualized server environment.

2.5.2. Reliance on Best Business Practices/Degree of Process Reengineering Imposed or Required. Describe in detail the best business practices that are built into your software. How do these practices pertain to County operations in particular? Describe how the proposed solution may be incorporated into an ITIL based environment?

2.5.3. Workflow Capabilities. How does workflow (electronic routing of documents) in the system operate? Describe the process for how workflow rules are established, maintained, controlled, and reported (for audit trail purposes)? How does workflow interface with popular e-mail programs, such as Microsoft Outlook? Describe how workflow capabilities may be used to complete required tasks within the proposed solution.

2.5.4. Administration/Development Toolsets. What application toolsets are included with the software? What unique programming requirements are there? What tools are available to customize the software (e.g., add fields, create new tables, change menus, etc.)? Should customizations be necessary, what audit trails exist for those customizations? What training will be provided as part of this solution to educate County staff about the toolsets?

2.5.5. Security. What security tools are included with the software? How do restrictions to the following work: administrative tool access; application module access; menu access; record level access; field level access; and querying/reporting access? What is included in the user security profile? How is the security profile defined? What audit trail capabilities exist to track changes to a security profile (e.g. what changes were made and who made them)? How may security processes be segregated between Information Technology (creation of security roles) and business units (assignment of security roles to users)?

2.5.6. Upgrade tools. What is the upgrade frequency? How are patches and fixes deployed? How are patches and fixes applied? How are upgrades applied? What happens to software customizations (e.g., user-defined tables, fields and business logic) during the upgrade? How many versions of the software does your company support as part of regular mainstream maintenance? How long does a typical upgrade take to implement, in an organization the size of the County? What resources would typically be required to implement these patches?

2.5.7. Reporting and Analysis Tools. What reporting tools are available? Do the same security definitions apply to the reporting tools as established in the main solution? Provide a list of standard reports, by module, that come “out of the box” with the software.

2.6 Third-Party Products (Section 5.0)

To the extent that a third-party product is required to compensate for functionality absent in the solution, the Offeror shall explicitly state the name of any third-party product. For each third-party product, proposals shall include a statement documenting whether the Offeror’s contract will encompass the third-party product and/or whether the County will have to contract on its own for the product. The County prefers that the software Offeror serve as the administrator for all third-party software contracts and maintenance agreements.

Finally, the Offeror should provide proof that they have access to the third-party software source code (own or in escrow) and that the Offeror has the ability to provide long-term support for the

third-party software components of their system. Proposals should also address how third party interfaces (and any customizations to the third party software) are maintained during the enterprise software upgrade process.

2.7 Implementation Plan (Section 6.0)

The Offeror shall provide a detailed plan for implementing the proposed solution. This information MUST include:

- Detailed methodology and plan for implementing the solution. The implementation plan shall include the following elements: the estimated implementation timeframe; an overview of recommended project phases and major milestones; a matrix of proposed roles/responsibilities for County staff and the Offeror; and all project assumptions. The description of the implementation plan shall include the specific components which are included in each phase of the implementation based on the scope of work for the project. The implementation plan shall use Microsoft Project as the planning tool or be converted into the Microsoft Project format.
- Project organization chart showing both the County and Offeror staff.
- Work effort estimates. A “staff loading” chart, listing the estimated resource utilization (for both the County and Offeror staff) by month, shall be submitted on the form provided as Attachment B. Offerors are required to load the chart based on the proposed implementation schedules provided in Section 1.3 of this RFP. The County reserves the right to alter work effort based on further discussion with the Offeror.
- Based on the responses to the County functional/technical requirements, the estimated level of work effort required for software customizations (e.g., changes to source code) in order for the software to meet the stated business requirements of the County.
- Resumes and qualifications of the Proposed Project Manager, Proposed Implementation Personnel and the Managing Partner.

Proposals shall include <u>all</u> modules that the County needs to attain the functionality stated in the detailed requirements spreadsheets in this RFP. Furthermore, all consulting hours needed to deliver the functional requirements (including customization, configuration, and reporting, etc.) shall be included in the cost proposal.

2.8 Training and Change Management (Section 7.0)

The Offeror shall provide a training overview that includes:

- Overview of proposed training plan/strategy, including options for on-site or off-site training services, for the core project team, end-users, and technology personnel.
- The role and responsibility of the Offeror in the design and implementation of the training plan (e.g., development of customized training materials, delivering training to County end-users).
- The role and responsibility of County staff in the design and implementation of the training plan.
- The knowledge transfer strategy proposed by the Offeror to prepare County staff to maintain the system after it is placed into production.

- Descriptions of applicable Classes/Courses proposed in the training plan. (The Offeror shall specify the unit of measure for its training (e.g., units, classes, days, etc.) and define the hours associated with these units of measure.)
- Use of third-party training resources. Offeror shall identify third party partners that provide training on the use of their solution and identify if third party training is included in the solution proposal. If a third party resource is to be used for training purposes their contact information must be identified as defined in section 2.6 Third Party Products.
- The Awareness, Desire, Knowledge, Ability, Reinforcement (ADKAR) change management model is used with the County for user education and adoption. The selected Offeror shall provide information about how they will work with County change management champions to increase the adoption and acceptance of the new system. Change Management assumptions made by the Offeror must be clearly defined in this response section.

2.9 Maintenance and Support Programs (Section 8.0)

Specify the nature of any post-implementation and on-going support provided by the Offeror including:

- On-site, post-implementation support (e.g., one month of on-site support after go-live, optional “as-needed” support (7days/week)).
- Telephone support (include toll-free support hotline, hours of operation, availability of 24 x 7 hotline, etc.).
- Tiered customer support levels (e.g., gold, silver, etc.) must be identified in the response. Define what level of support is being proposed.
- Delivery method of future upgrades and product enhancements including historical frequency of upgrades by module.
- Any anticipated mid-implementation upgrades. If any are planned, the estimated work effort and related costs associated with such tasks should be included in the proposal.
- Availability of user groups and their geographic areas.
- Problem reporting and resolution procedures.
- Bug fixes and patches.
- Support provided for third-party solutions.
- Other support (e.g., on-site, remote dial-in, Web site access to patches, fixes and knowledge base) and any limitations on the number of County personnel that may access other support methods.

2.10 Essay Response(s) (Section 9.0)

The County has some unique business process needs that must be accommodated in this solution. Offerors are required to answer the following questions addressing these requirements (minimum of one paragraph response). These questions may appear again during solution demonstrations, discovery sessions and during contract negotiations.

2.10.1. Describe the process used by the proposed solution to ensure that data normalization is utilized and that data is not entered in multiple tables to allow

operation of a specific module or to improve system performance. Describe the controls that exist, if any, to ensure that data integrity is maintained.

2.11 Responses to Functional/Technical Requirements (Section 10.0)

Responses to the requirements listed in Attachment A of this RFP shall be provided in this section of the Offeror's proposal. Offerors are required to use the format provided and add explanatory details as necessary in the "Comments" column or in a separate spreadsheet that references the requirement number. Offerors must identify the assumptions used to answer each specific business requirement using the "Assumptions" column in Attachment A. Additionally, Offerors should indicate all software modules / sub-modules required to fulfill the business requirement in the "Modules / Sub-modules Required" column. Offerors must fully answer each business requirement, even if seemingly a duplicate requirement, as each requirement is given from a specific point of view. The following answer key should be used when responding to the requirements:

F = Fully Provided "Out-of-the-Box"
CO = Configuration (no changes to source code) Settings Using System Screens
R = Provided with Reporting Tool
CU = Customization (requiring changes to delivered system) Unique to Collin County
NV = Provided in the Very Next Version
NA = Not Available
TP = Third Party Software Required

Note: Offerors shall use only one response code per requirement. Any requirement that is not answered utilizing a single code as outlined above will be treated as a negative/non-response. The selected Offeror shall warrant that the proposed solution will conform in all material respects to the requirements and specifications as stated in this RFP. That is, the detailed requirements as stated in this RFP will become part of the solution and implementation services contracts and agreements and will be warranted as such. **By virtue of submitting a response the Offeror agrees that the responses documented in Attachment A will become part of the contract documents.**

2.12 Client References (Section 11.0)

The County considers references for Offerors to be important in its decision to award a contract. All references provided will be contacted by the County during the selection process. The County will not work through an Offeror's Reference Manager to complete a reference— Offeror's shall provide a direct client reference who was involved in an Offeror led project.

SOFTWARE RESPONDENTS – Software firms shall provide at least five (5) client references that are similar in size and complexity to this procurement (preferably Counties) and have utilized the proposed system in a comparable computing environment. (Reference forms are attached to this proposal, Attachment D.) Submit references for fully completed (live) installations. Include one reference for a severed relationship and the reason the relationship was terminated, if applicable, in addition to the five client references.

IMPLEMENTATION FIRMS – Implementation firms shall also provide five (5) references for sites similar to this procurement (preferably Counties) where they have implemented the software being proposed. (Reference forms are attached to this proposal, Attachment E.) References should be submitted where the implementation firm was the primary consultant and installer of the base solution for completed installations. Include one reference for a severed relationship and

the reason the relationship was terminated, if applicable, in addition to the five client references. If the Software Firm implements their own solutions, and that is being proposed for Collin County, then separate Implementation Firm Reference Forms may be omitted.

THIRD PARTY FIRMS – Using the forms attached to this RFP (Attachment F), third-party firms addressing particular functionality should provide at least three (3) references that are similar in size and complexity to this procurement (preferably Counties) and that have been used in conjunction with the software solution proposed for this engagement. Submit references for fully completed (live) installations.

2.13 Cost Proposal (Section 12.0)

The cost proposal shall include all costs related to implementing the detailed business requirements, found in Attachment A, in this RFP whether such implementation requires customization to the solution or not. Offerors are required to provide costs based on the implementation schedules provided in Section 1.3 of this RFP. The County may award a purchase contract based on initial offers received without discussion of such offers. An Offeror's initial offer should, therefore, be based on the most favorable terms available. The County may, however, hold discussions with those Offerors that it deems, in its discretion, to fall within a competitive range. It may also request revised pricing offers from such Offerors and make an award and/or conduct negotiations thereafter.

Cost schedules shall be presented in the spreadsheet format presented in Attachment C of this RFP and submitted in Microsoft Excel. Any software required as a pre-requisite to the installation, configuration and use of the proposed solution must be identified separately in the Pre-requisite Software section of Attachment C, Page 2. Pre-requisite Software pricing should be based on current commercial retail rates. The County reserves the right to contact Offerors on cost and scope clarification at any time throughout the selection and negotiation process. The County is asking Offerors to estimate costs for all categories with the understanding that they may have to make assumptions. Such assumptions shall be documented in each proposal. Failure to fully provide cost and work effort estimates may lead to elimination prior to presentations.

Use the following information to assist in estimating costs:

Operating Budget:	$175 million
Number of Employees:	Approximately 1,700
Healthcare Clinic Annual Visits:	Approximately 10,000
Preferred Training Strategy:	ILT for project team and SME ILT / CBT for medium and heavy users Train the trainer for inquiry only training

2.14 Exceptions to the RFP (Section 13.0)

All requested information in this RFP shall be supplied with the proposal. Offerors may take exception to certain requirements in this RFP. All exceptions shall be clearly identified in this section and the written explanation shall include the scope of the exceptions, the ramifications of the exceptions for the County, and the description of the advantages or disadvantages to the County as a result of such exceptions. The County, at its sole discretion, may reject or accept any exceptions or specifications within the proposal.

2.15 Sample Documents (Section 14.0)

To establish a complete and competitive proposal, Offerors should include sample copies of the following documents:

- Sample training manuals
- Sample user guides
- Sample functional, technical and support documentation
- Sample software license agreement
- Sample Implementation Services Agreement
- Sample maintenance and support agreement

Part 3 Evaluation Methodology

3.1 Evaluation Criteria

A County Selection Team will review all proposals received by the Opening date and time as part of a documented evaluation process. For each decision point in the process, the County will evaluate suppliers according to specific criteria and will elevate a certain number of suppliers to compete against each other. The proposals will be evaluated on the following criteria (not necessarily listed in order of importance):

- Conformance with RFP guidelines and submittal requirements
- Compatibility with the County's desired current and future technology architecture, expertise, and future strategy/Responses to Technical Requirements
- Public Sector Experience and References
- Implementation Strategy and Plan
- Responses to Functional Business Requirements
- Compatibility with the County's desired terms and conditions
- Cost
- Product Demonstrations and Implementation Services Interviews (optional)
- Site Visits (optional)

The County reserves the right to determine the suitability of proposals on the basis of all of these criteria.

The County will use a competitive process based upon "selection levels." The County reserves the right that if an Offeror fails to meet expectations during any part of the process, the County may proceed with the remaining Offerors or elevate an Offeror that was not elevated before. The selection levels are described in the following sections.

Level 1 - Procurement Requirements Assessment

Criteria assessed during Level 1:

- Conformance with RFP guidelines and submittal requirements.
  - Response to General Requirements as stated in Section 2.1 to include

Section	Title
	Title Page
	Letter of Transmittal
	Table of Contents
1.0	Executive Summary (include signature page – Attachment G)
2.0	Scope of Services
3.0	Company Background
4.0	Proposed Application Software and Computing Environment
5.0	Third-Party Products
6.0	Implementation Plan (Attachment B & H)
7.0	Training

8.0	Maintenance and Support Programs
9.0	Essay Responses
10.0	Responses to Functional/Technical Requirements (Attachment A)
11.0	Client References (Attachment D, E, F)
12.0	Cost Proposal (Attachment C
13.0	Exceptions to the RFP
14.0	Sample Documents

Level 2 – Detailed Proposal Assessment

The County's Selection Team will conduct a detailed assessment of all proposals elevated to this Level. Criteria evaluated in Level 2:

- Compatibility with the County's desired current and future technology architecture, expertise, and future strategy/Responses to Technical Requirements – 15%
  - Those suppliers whose capabilities are best aligned with the technology strategy, knowledge of County IT staff, and architecture will be evaluated more favorably.

- Public Sector Experience/Focus and References – 15%
  - Suppliers who have proven experience at public sector sites similar in scope, size and complexity to the County will provide higher confidence to County evaluators. References may be called during this phase of the evaluation and the quality of the clients provided as references will be analyzed. Suppliers who provide clients with live implementations of the version of the software proposed to the County are the most desirable. The listing of all public sector clients provided in the RFP will also be used during this evaluation. Suppliers who have a proven focus solely on public sector customers will be rated more favorably.

- Implementation Strategy and Plan – 15%
  - County evaluators will examine implementation methodologies and plans that are well suited for the County. This analysis will include staffing effort, staffing level, implementation schedule, team structure (Offeror employed implementation resources, contracted implementation staff), team composition (project managers, team leads, etc.), interface and data conversion estimates, training and change management strategies. The County will also examine Return on Investment (ROI) documentation for the proposed solution which will detail cost benefits to the County on the basis of detailed process efficiencies.

- Responses to Functional Business Requirements – 25%
  - The County will analyze the suppliers' responses to the detailed business requirements. A Business Requirement will be considered a "fit" with the response of "F" or "CO".

- Cost – 30%
  - The individual components that comprise the total cost of the software implementation will be included in this portion of the evaluation. Cost of software licenses, implementation effort, training, travel, and maintenance and support will be analyzed. Suppliers shall provide cost information in the format requested on the cost spreadsheets in Attachment C.

It is anticipated that no more than three suppliers will advance to Level 3 but Collin County reserves the right to adjust the number as necessary.

Level 3 - Demonstrations and Implementation Firm Interviews

The following criteria are optional, at the County's discretion, and will be used to evaluate those Offerors elevated for on-site product demonstrations and implementation interviews.

- Product Demonstrations, Product Lab, and Implementation Interviews – 50%
  - During the demonstrations and interviews, the County will assess the "look and feel" of the proposed product using detailed scripts tailored to reflect County business processes. Several of the other evaluation criteria will be clarified and refined, including the implementation strategy and plan, technology compatibility, ability to meet business requirements, and cost. In addition to the scripted demonstrations, the County will request that all Offerors elevated to this level staff a product lab to allow County staff to "touch and feel" the product with Offeror staff available to respond to questions. The product lab will be held concurrently with the product demonstration sessions. County attendees will likely move from the demonstration session to the product lab as their subject area is reviewed in the demonstration process.

- Public Sector Experience and References – 50%
  - The County will contact the software and implementation firm references. These references will be asked a series of questions regarding their satisfaction with the software and the performance of the implementation supplier.

It is anticipated that no more than two suppliers will advance to Level 4 but Collin County reserves the right to adjust the number as necessary.

Level 4 – Discovery Sessions

Suppliers elevated to Level 4 will be asked to respond in writing to issues and questions stemming from early evaluation levels, the product demonstrations and implementation interviews, as well as any other cost and implementation planning considerations in the proposal, and may be invited to present their responses on-site. These on-site meetings may include additional demonstrations of the product and an opportunity for the County evaluators to have other questions and concerns addressed. The County reserves the right to bypass Level 3 in the evaluation process and move directly to Discovery Sessions. Criteria evaluated during this phase include:

- Updated Implementation Strategy and Plan – 35%

- Updated Cost – 35%

- Compatibility with the County's desired terms and conditions – 30%

- Site Visits (Optional)
  - The County may choose to visit sites where the proposed solution is installed in a live production setting.

Based on the information collected in this phase, a single supplier or supplier team will be identified as the finalist for contract negotiations. If a contract cannot be reached after a period of time deemed reasonable by the County, it reserves the right to contact any of the other suppliers that have submitted bids and enter into negotiations with them.

Level 5 –Contract Negotiations

The Offeror will work with the County to develop required contract documents which outline the statement of work, deliverables, milestones, roles and responsibilities, and other key issues that affect the cost, quality and success of the implementation. The functional and technical

requirements spreadsheets, Attachment A, will be attached to the contract documents as stated in section 2.11 of this RFP.

3.2 Award

The County will select the best respondent whose proposal has been evaluated as the most responsive and responsible for the County with the best cost as may be finally determined by Commissioners' Court. Contractual commitments are contingent upon the availability of funds, as evidenced by the issuance of a purchase order. All contracts are subject to the approval of the County's legal counsel and Commissioners' Court, prior to execution. Once awarded, the contract will be the final expression of the agreement between the parties and may not be altered, changed, or amended except by mutual agreement, in writing.

Part 4 Attachments

Attachments

Attachment A: Collin County Detailed Business Requirements
Attachment B: Staffing Level Worksheet
Attachment C: Proposed Cost Schedule
Attachment D: Software Firm Reference Form
Attachment E: Implementation Services Firm Reference Form
Attachment F: Third Party Firm Reference Form
Attachment G: Collin County Generated Forms
Attachment H: Mandated Forms
Attachment I: Direct Patient Care Workflows
Attachment J: Internal Workflows and Business Scenarios
Attachment K: Collin County Terms and Conditions
Attachment L: Insurance Requirements

Attachment A: Collin County Detailed Business and Functional Requirements

Refer to document Attachment A - Collin County Detailed Business and Functional Requirements.xls

Attachment B: Staffing Level Worksheet

Refer to document Attachment B - Staffing.xls

Attachment C: Proposed Cost Schedule

Refer to document Attachment C - Cost.xls

Attachment D: Software Firm Reference Form

Provide at least five (5) client references that are similar in size and complexity to this procurement (preferably Counties) and have utilized the proposed system in a comparable computing environment.

Organization Name:			
Organization Project Manager:		Phone:	
		Email:	
Organization Address:			
Implementation Period:		through	
General Operating Budget:		Employees:	
Project Summary:			

Project Scope			
General Ledger		Accounts Payable	
Accounts Receivable		Project Accounting	
Grant Accounting		Investment	
Budget		Purchasing	
Fixed Assets		Inventory	
Development Services		Facility Work Orders	
Public Works			

Project Budget			
Hardware Cost:		Software License Cost:	
Data Conversion Cost:		Implementation Cost:	
Interface Development Cost:			

Project Infrastructure	
Hardware Platform:	
OS Platform/Version:	
Database Platform:	
Required Data Storage:	

Attachment E: Implementation Services Firm Reference Form

Provide at least five (5) client references that are similar in size and complexity to this procurement (preferably Counties) and have utilized the proposed system in a comparable computing environment.

Organization Name:			
Organization Project Manager:		Phone:	
		Email:	
Organization Address:			
Implementation Period:		through	
General Operating Budget:		Employees:	
Project Summary:			

Project Scope			
General Ledger		Accounts Payable	
Accounts Receivable		Project Accounting	
Grant Accounting		Investment	
Budget		Purchasing	
Fixed Assets		Inventory	
Development Services		Facility Work Orders	
Public Works			

Project Budget			
Hardware Cost:		Software License Cost:	
Data Conversion Cost:		Implementation Cost:	
Interface Development Cost:			

Project Infrastructure	
Hardware Platform:	
OS Platform/Version:	
Database Platform:	
Required Data Storage:	

Attachment F: Third Party Firm Reference Form

Provide at least five (5) client references that are similar in size and complexity to this procurement (preferably Counties) and have utilized the proposed system in a comparable computing environment.

Organization Name:			
Organization Project Manager:		Phone:	
		Email:	
Organization Address:			
Implementation Period:		through	
General Operating Budget:		Employees:	
Project Summary:			

Project Scope			
General Ledger		Accounts Payable	
Accounts Receivable		Project Accounting	
Grant Accounting		Investment	
Budget		Purchasing	
Fixed Assets		Inventory	
Development Services		Facility Work Orders	
Public Works			

Project Budget			
Hardware Cost:		Software License Cost:	
Data Conversion Cost:		Implementation Cost:	
Interface Development Cost:			

Project Infrastructure	
Hardware Platform:	
OS Platform/Version:	
Database Platform:	
Required Data Storage:	

Attachment G: Collin County Generated Forms

Attachment G includes most of the clinic-generated correspondence and forms used by Collin County Health Care Services. The EMRS system selected shall be fully customizable in the sense that it allows end users to independently create and edit electronic form templates for generating forms and form letters such as those in Attachment B. EMRS system selected shall also be able to populate patient data into templates created by CCHC for ease of form/form letter printing.

Attachment H: Mandated Forms

Attachment H includes most of the common state-mandated/federally mandated forms currently used by Collin County Health Care Services. The EMRS system selected shall be able to populate patient data into and replicate state/federally mandated forms exactly.

Attachment I: Direct Patient Care Workflows

Attachment I includes the Direct Patient Care Workflows desired for an EMRS system by Collin County Health Care Services for its various clinics. The EMRS system selected shall accommodate these workflows.

Attachment J: Internal Workflows and Business Scenarios

Attachment J includes the Internal Workflows and Business Scenarios desired for an EMRS system by Collin County Health Care Services for its various clinics. The EMRS system selected shall accommodate these workflows.

Attachment K: Collin County Terms and Conditions

Attachment L: Insurance Requirements

Attachment A: Collin County Detailed Business Requirements

Functional Category: General Technical Requirements

F = Fully Provided Standard Functionality with No Setup Required
NV = Provided in the Very Next Version
TP = Third Party Software Required
CO = Configuration (no changes to source code) Settings Using System Screens
R = Provided with Reporting Tool
CU = Customization (requiring changes to delivered system) Unique to Collin County
NA = Not Available

Reference Number		Functional Requirements	Response	Answer Submitted	Module(s)/Sub-module(s) Required to Fulfill Requirements	Assumptions	Comments
		GENERAL REQUIREMENTS					
TECH	1.00	All suites/modules/applications of the solution are fully integrated. Specifically, updating of any data element occurs only once, and is then reflected throughout all applications.		NR			
TECH	2.00	Support of both on-line immediate updates as well batch processing for all transactions.		NR			
TECH	3.00	System-wide inquiry ability to any module, with role based security control.		NR			
TECH	4.00	System has one common database.		NR			
TECH	5.00	System is normalized, with all unique data elements occurring only once in the database.		NR			
TECH	6.00	System is fully browser based (i.e., all suites/modules/applications) and no client side code is required for normal end user access.		NR			
TECH	7.00	Use of multiple types of network connections including:					
TECH	7.01	TCP/IP		NR			
TECH	7.02	Ethernet		NR			
TECH	8.00	Use of the following database platforms:					
TECH	8.01	Microsoft SQL Server		NR			
TECH	9.00	Support of operating / network platforms:					
TECH	9.01	Microsoft NT		NR			
TECH	10.00	Delivered interfaces with imaging and bar-coding hardware/software. Please utilize the comments column to indicate with which scanning and bar-coding systems you interface.		NR			
TECH	11.00	Modules support attached documents of any file type (e.g., ability to attach any electronic documents to any module).		NR			
TECH	12.00	Microsoft Outlook support as the e-mail client.		NR			

Attachment A: Collin County Detailed Business Requirements

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Reference Number		Functional Requirements	Response	Answer Submitted	Module(s)/Sub-module(s) Required to Fulfill Requirements	Assumptions	Comments
TECH	13.00	Remote Intranet and Internet access while maintaining strict security of data through role based security for both internal (County employees) and external (public constituents) users.		NR			
TECH	14.00	Support of faxing or email as a native output option selectable by the user at the time the output is required.		NR			
TECH	15.00	Workflow system provides communication routing throughout all suites/modules/applications.		NR			
TECH	16.00	Support of electronic signatures and digital certificates.		NR			
TECH	17.00	User-friendly view of the system:					
TECH	17.01	Browser-based application		NR			
TECH	17.02	Ability to navigate quickly through screens and menus		NR			
TECH	17.03	Powerful and customizable search engine		NR			
TECH	17.04	Terminology that is pertinent to government functionality		NR			
TECH	17.05	All user data and field labels use English-language text as opposed to code-based representations or elements		NR			
TECH	18.00	Based upon users' security role, allow custom screens specific to their user ID for:					
TECH	18.01	Input screens		NR			
TECH	18.02	Menus, including Help menus		NR			
TECH	18.03	Notices		NR			
TECH	18.04	Default field values		NR			
TECH	18.05	Workflow notices and worklist items		NR			
TECH	18.06	Context-sensitive help screens based on user's application privileges and where they are in the application		NR			

Attachment A: Collin County Detailed Business Requirements

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Reference Number		Functional Requirements	Response	Answer Submitted	Module(s)/Sub-module(s) Required to Fulfill Requirements	Assumptions	Comments
TECH	19.00	Access to input screens and modules without having to back out of existing navigation path to return to a base starting menu.		NR			
TECH	20.00	Support short-cuts to move between modules and menus.		NR			
TECH	21.00	Support of multiple concurrent screens/windows/sessions.		NR			
TECH	22.00	Use of on-line drop-down lists for all valid values for each validated field.		NR			
TECH	23.00	Partial queries or "wildcard" functionality in fields.		NR			
TECH	24.00	Customizable on-line tutorial for each module maintainable by the County and specific to county business processes.		NR			
TECH	25.00	Copy one line of field values to the next line and change one or more field value elements when using input screens.		NR			
TECH	26.00	Effective dates (past and future) for all transactions.		NR			
TECH	27.00	Time and date stamps applied to all transaction data.		NR			
TECH	28.00	Toolsets to enable the County to be self sufficient to complete the following without requiring vendor involvement:					
TECH	28.01	Report design		NR			
TECH	28.02	Security administration		NR			
TECH	28.03	Application upgrade administration		NR			
TECH	28.04	Archiving and purging of data		NR			
TECH	29.00	Provide keystrokes for rapid data entry and movement from screen to screen ("hotkeys" or coding reduction techniques).		NR			
TECH	30.00	End user screens contain triggers to additional data screens based on specific data input.		NR			
TECH	31.00	Mass changes or mass deletes supported by table-driven data with proper security.		NR			
TECH	32.00	Consistent user interface across all components utilitzing only web browser components with no client side code required for regular end users..		NR			

Attachment A: Collin County Detailed Business Requirements

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Reference Number		Functional Requirements	Response	Answer Submitted	Module(s)/Sub-module(s) Required to Fulfill Requirements	Assumptions	Comments
TECH	33.00	Provide descriptive error messages.		NR			
TECH	34.00	Utilize on-line error message help screens, which can be accessed directly from the error message, by selecting a "details" link.		NR			
TECH	35.00	Error messages appear in a consistent format across all system modules, with like codes, text, and screen locations.		NR			
TECH	36.00	Highlight required elements upon transaction entry to identify any missing information.		NR			
TECH	37.00	Allow only current dated table values in fields requiring validated values.		NR			
TECH	38.00	Store and save user profile preferences, such as font, colors, column and field locations, etc.		NR			
TECH	39.00	Users to have access to the system 24 hours/day, 7 days/week.		NR			
TECH	40.00	Determine which employees are utilizing the system at any point in time, with appropriate security control.		NR			
TECH	41.00	Backup and restore each individual application.		NR			
TECH	42.00	Work with the Collin County Web site as the initial portal to the ERP system (ERP must work within the County's menu structure).		NR			
		WORKFLOW					
TECH	43.00	Workflow rules are based upon the following:					
TECH	43.01	Tolerances		NR			
TECH	43.02	Events or "triggers"		NR			
TECH	43.03	Financial rules		NR			
TECH	43.04	User-defined parameters		NR			
TECH	44.00	Provide a flexible, hierarchical approval process based on a user defined reporting structure.		NR			

Attachment A: Collin County Detailed Business Requirements

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Reference Number		Functional Requirements	Response	Answer Submitted	Module(s)/Sub-module(s) Required to Fulfill Requirements	Assumptions	Comments
TECH	45.00	Track and report electronic approvals.		NR			
TECH	46.00	Record freeform text in comment fields.		NR			
TECH	47.00	Set number of approvals required by type of transaction or threshold such as dollar value.		NR			
TECH	48.00	Ability to automatically re-route transactions, using a designated surrogate or a hierarchical reporting structure, if an individual does not act within a specified timeframe.		NR			
TECH	49.00	Provide notifications to parties involved in workflow chain when escalation is needed.		NR			
TECH	50.00	Capture performance statistics, either budget based measures or ad-hoc, based on workflow activity (or inactivity).		NR			
TECH	51.00	Process for individuals with higher levels of authority to approve transactions that have not been approved by individuals with lower levels of authority.		NR			
		AUDIT					
TECH	52.00	Deliver an automated audit trail of system transactions.		NR			
TECH	53.00	Record the following minimum data on all transactions:					
TECH	53.01	Type of change		NR			
TECH	53.02	Log On ID		NR			
TECH	53.03	Effective Date of Change		NR			
TECH	53.04	Date		NR			
TECH	53.05	Time		NR			
TECH	53.06	Old value		NR			
TECH	53.07	Transaction Type		NR			

Attachment A: Collin County Detailed Business Requirements

Functional Category: General Technical Requirements

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R = Provided with Reporting Tool
CU = Customization (requiring changes to delivered system) Unique to Collin County
NA = Not Available

Reference Number		Functional Requirements	Response	Answer Submitted	Module(s)/Sub-module(s) Required to Fulfill Requirements	Assumptions	Comments
TECH	53.08	Transaction ID		NR			
TECH	54.00	Authorized users may define record retention periods, specific to individual record categories, with approval/override by the IT records administrator.		NR			
TECH	55.00	Deliver an archive process defineable by system administrator.		NR			
TECH	56.00	Audit reports to ensure that all data is archived before being purged.		NR			
		QUERYING AND REPORTING					
TECH	57.00	Reporting tools for drill down, drill up, and/or drill around (create cross tabs) to supporting documents and related transactions from any field within the system.		NR			
TECH	58.00	Tools to generate ad hoc queries and reports based on user-defined parameters.		NR			
TECH	59.00	Delivered ad-hoc query tools can access any field(s) within the system.		NR			
TECH	60.00	Export to, and import from, popular desktop word processing and spreadsheet applications.		NR			
TECH	61.00	Produce ad hoc reports online or printed hard copy.		NR			
TECH	62.00	Route reports to various network printers as defined by the user.		NR			
		SECURITY					
TECH	63.00	Restrict access to data fields and windows to users with proper role based security.		NR			
TECH	64.00	Limit the types of transactions that a user can process based on assinged security role.		NR			
TECH	65.00	Natively support a minimum of 128 bit data encryption, for data being sent out from or received by the County via the Intranet or Internet.		NR			
TECH	66.00	Decentralized security administration to enable IT department to create/maintain defined security roles while designated "super users" are enabled to assign a security role to a user.		NR			
TECH	67.00	Security roles by groups or classes (user profiles).		NR			

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TECH	68.00	Deliver standard report on unused or inactive user ids.		NR			
TECH	69.00	Native integration to LDAP systems such as Active Directory for user login and authentication as well as password change requirements.		NR			
TECH	70.00	Recognize any valid Active Directory User ID and Password.		NR			
TECH	71.00	Suspend User ID after administrator defined number of failed login attempts and send workflow notice to system administrator(s) of the failed attempt.		NR			
TECH	72.00	Log off idle user accounts based on a time out period defined by system administrator(s).		NR			
TECH	73.00	Deliver workflow notices and report of failed login attempts.		NR			

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		SYSTEM ARCHITECTURE AND MAINTENANCE					
A	1.00	Provide a hosted, customizable EMRS solution with high availability		NR			
A	2.00	Provide a system with client/server architecture that operates in a Windows environment.		NR			
A	3.00	Provide a system that employs a centralized relational database.		NR			
A	4.00	Allow the system to operate on both local and wide area networks, linking all practice sites and databases. Able to securely move information from one database to another.		NR			
A	5.00	Allow full system functionality from any workstation within the network with a single sign on.		NR			
A	6.00	Provide a scalable system that can be expanded easily as our facility grows.		NR			
A	7.00	Provide an operational environment which will ensure the security and integrity of the system and all its data.		NR			
A	8.00	Provide for redundant storage of all system data files.		NR			
A	9.00	Provide for redundant processing capabilities to protect against processor failures.		NR			
A	10.00	Provide a check-point recovery capability to restore data files after a system failure.		NR			
A	11.00	Provide expanded descriptions for error messages.		NR			
A	12.00	Please describe any scheduled maintenance procedures.		NR			
A	13.00	Please describe any disaster recovery features and/or protocols		NR			
		SECURITY AND AUDITING					
B	1.00	Provide a system that is completely HIPAA compliant. Please explain.		NR			
B	2.00	Provide a multi-level security system to ensure the confidentiality of patient-related information and to control access to system functions and features.		NR			

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B	3.00	Restrict access to specific areas of the application based on system function to be performed.		NR			
B	4.00	Restrict access to specific patient records based on specific tests performed.		NR			
B	5.00	Allow password protection at different levels.		NR			
B	6.00	Allow a user of proper security clearance to modify the database parameters once the system is live, without requiring programming knowledge.		NR			
B	7.00	Restrict access to configuration tables, profile indexes, etc. to designated lab personnel via security controls.		NR			
B	8.00	Maintain an automated system log of user sign-on activity.		NR			
B	9.00	Maintain an audit trail for system entries including user code, date, and time of each system transaction.		NR			
B	10.00	Provide multi-level password security down to options within menus.		NR			
		EQUIPMENT NTERFACING					
C	1.00	Provide operational software or interfaces for the following equipment and/or applications (Please provide a functional description of each interface available):					
C	1.01	Chemistry Analyzer		NR			
C	1.02	Immunoassay Analyzer		NR			
C	1.03	Hematology Analyzer		NR			
C	1.04	Coagulation Analyzer		NR			
C	1.05	Urine Strip Reader		NR			
C	1.06	Microbiology Analyzer		NR			
C	1.07	Other laboratory instruments		NR			

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Reference Number		Functional Requirements	Response	Answer Submitted	Module(s)/Sub-module(s) Required to Fulfill Requirements	Assumptions	Comments
C	1.08	Practice Management System		NR			
C	1.09	Billing System		NR			
C	1.10	Electronic Medical Record		NR			
C	1.11	Reference Laboratory		NR			
C	2.00	Allow analyzer interfaces to operate so that result verification and reporting can be performed simultaneously at multiple workstations.		NR			
		SYSTEM INTERFACING/COMPATIBILITY					
D	1.00	Provide a system that is compatible and/or can successfully interface with a variety of auxilliary applications such as:					
D	1.01	Health Level 7 (HL7)		NR			
D	1.02	SNOMED		NR			
D	1.03	SOAP		NR			
D	1.04	XML		NR			
D	1.05	AS400		NR			
D	1.06	PhoneMaster (for appointment reminders by phone)		NR			
		ORDER ENTRY					
E	1.00	Allow multiple tests ordering for a single patient using a common demographic record.		NR			
E	2.00	Allow laboratory orders to be entered from an off-site location.		NR			
E	3.00	Allow the lab to develop and customize orderable items.		NR			
E	4.00	Allow simple test ordering: Single header linked to a single test result field (e.g. Glucose).		NR			

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E	5.00	Allow compound test ordering: Single header linked to multiple test result fields (e.g. CBC, Lipid Panel, and Comprehensive Metabolic Panel).		NR			
E	6.00	Allow the user to order tests by entering test codes and/or by selecting from a test menu.		NR			
E	7.00	Automatically alerts users to previously ordered lab work.		NR			
E	8.00	Allow at the time of ordering a request that patient lab results be sent to more than one provider.		NR			
E	9.00	Allow the cancellation of orders for patients who do not show for appointment.		NR			
E	10.00	Provide Medical Necessity validation based on lab-defined valid diagnosis codes for each applicable test.		NR			
E	11.00	Allow the generation of Medicare-compliant ABN forms when test ordering fails medical necessity validation.		NR			
E	12.00	Allow entry of four diagnosis codes for each ordered test.		NR			
E	13.00	Provide automatic testing destination routing as specified in payer's contract.		NR			
E	14.00	Provide automatic label printing as orders are entered.		NR			
E	15.00	Allow lab-defined label configuration.		NR			
E	16.00	Describe the bar code formats your EMRS accepts and prints for lab samples		NR			
E	17.00	Provide the specific sample requirements or sample tube types at the time of order entry.		NR			
E	18.00	Store diagnosis codes in registration function.		NR			
E	19.00	Support retrieval of patient records by partial (e.g. first few letters of) patient last name.		NR			
E	20.00	Include test, profile, or battery name (mnemonic code) in order data.		NR			
E	21.00	Process orders for profiles that include multiple tests (e.g. cardiac enzyme profile).		NR			

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E	22.00	Allow a miscellaneous test code so previously undefined tests can be ordered and charged.		NR			
E	23.00	Ability to correct a field on a screen without having to re-enter entire order transaction.		NR			
E	24.00	Allow entry of orders for future dates.		NR			
E	25.00	Allow splitting one ordered test into more than one request (e.g. group tests, pre-op, and coag screen).		NR			
E	26.00	Automatically check for and warn of duplicate single test orders with profile orders.		NR			
E	27.00	Support cancellation of tests--logging accession #, test code, patient name, reason, date, time, and tech ID.		NR			
E	28.00	Provide simple method to order additional test requests on sample already received and processed in lab.		NR			
E	29.00	Allow cancellation of an order without canceling prior results.		NR			
E	30.00	Provide flexible, customizable Sample ID formats.		NR			
E	31.00	Print sample collection labels for timed and routine collections.		NR			
E	32.00	Allow for multiple labels per test to print.		NR			
E	33.00	Print instructions/comments (e.g. do not collect from right arm) on sample labels.		NR			
E	34.00	Print aliquot labels when more than one test is drawn in the same collection tube.		NR			
E	35.00	Provide that uncollected samples continue to appear on subsequent lists until cancelled or collected.		NR			
E	36.00	Provide for easy free text entry of information such as critical result notification, sample rejection, or culture sites.		NR			
E	37.00	Provide for intelligent prompting for accessioning; e.g. When a wound culture is ordered, the system prompts the user for site/location.		NR			
E	38.00	Provide easy access to sample requirements for laboratory users.		NR			

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E	39.00	Provide intelligent sample labeling – groups samples in chemistry together and prints on labels, while hematology tests print on separate label and microbiology prints separately. Allows for making the number of labels customizable for each test.		NR			
E	40.00	Provide intuitive user interface – easy to locate screens for accessioning, reporting queries, etc.		NR			
E	41.00	Provide for an easy, systematic, and logical method of adding, editing, or deleting tests in the test code dictionary.		NR			
E	42.00	When looking up a patient in the system, tests performed on that patient and test results are made available without additional steps.		NR			
		ORDER ENTRY					
F	1.00	Provide a solution to create and capture the following information during visit:					
F	1.01	Encounters		NR			
F	1.02	Allergies to food and drugs		NR			
F	1.03	Social history		NR			
F	1.04	Medical history		NR			
F	1.05	Clinical summary		NR			
F	1.06	Checklist of symptoms		NR			
F	1.07	Current Medications		NR			
F	1.08	Vitals		NR			
F	1.09	Progress notes		NR			
F	1.10	Templates for normal exams		NR			
F	1.11	Templates for abnormal exams		NR			

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	Reference Number	Functional Requirements	Response	Answer Submitted	Module(s)/Sub-module(s) Required to Fulfill Requirements	Assumptions	Comments
F	1.12	Custom letter generation for patient		NR			
F	1.13	Anatomical references and diagrams. Please describe.		NR			
F	1.14	Referrals		NR			
F	2.00	Ability to easily fax, print, and securely email notes		NR			
F	3.00	Allow for auto-generation of daily progress notes as staff works through the EMR and documents various actions during visit		NR			
		LAB RESULT REVIEW					
G	1.00	Provide automatic review of order and/or lab(s) requested to check for potential errors		NR			
G	2.00	Allow reporting of numerical results to lab-defined number of significant digits per test.		NR			
G	3.00	Allow reporting of alpha results: Single word (e.g. positive or negative) and free text (e.g. short phrases or longer paragraph).		NR			
G	4.00	Allow attachment of a comment to any test header or test field (e.g. allow free text and pre defined comments).		NR			
G	5.00	Ability to select between reportable and non-reportable comments.		NR			
G	6.00	Allow the user to accept, reject, or re-run a test.		NR			
G	7.00	Allow automatic calculations based on test results from other fields.		NR			
G	8.00	Allow the user to override current test results for a patient.		NR			
G	9.00	Allow the user to retain over-ridden results.		NR			
G	10.00	Provide identification of the verifying nurse or clinician when reporting results.		NR			
G	11.00	Allow patient test to be incomplete for at least 8 weeks in the system.		NR			
G	12.00	Provide capabilities for graphic display of test results.		NR			

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G	13.00	Maintain table of lab-defined panic, delta, and reference result ranges based on age and sex.		NR			
G	14.00	Describe the procedure for correcting test results that have been resulted. After correcting, are the corrections able to be altered?		NR			
G	15.00	Support entry of comments for non-numeric results and interpretative reporting in result entry screens.		NR			
G	16.00	Allow for a comment to be placed on the sample accordingly.		NR			
G	17.00	Provide for release of results after they have been reviewed and approved by technical personnel (there is no merging function).		NR			
G	18.00	Provide the ability to access all patients of a particular client by name, date, or date range.		NR			
G	19.00	Allow look-up of patient and patient results by client number.		NR			
G	20.00	Allow for unlimited “canned comments.”		NR			
G	21.00	Allow comments to be attached to specific tests & specific clients such as “Current Dosage_____” attached to Protime tests.		NR			
G	22.00	Ability for verification of profile components with results released individually.		NR			
G	23.00	Provide automated calculation of health status alerts or health maintenance items (e.g. Clinical Decision Support)		NR			
G	24.00	Provide automated real-time clinical/health status alerts		NR			
		LAB RESULT REPORTING					
H	1.00	Provide automatic print reporting capabilities to laser printers.		NR			
H	2.00	Provide scheduler for automatic result delivery.		NR			
H	3.00	Provide automatic critical results notification		NR			
H	4.00	Provide automatic fax reporting capabilities.		NR			
H	5.00	Provide ability to securely send patient reports via the Internet.		NR			

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H	6.00	Provide ability to securely e-mail reports.		NR			
H	7.00	Automatically maintain a record of reports delivered by each reporting modality (FAX, Printer, and E-Mail, etc.). Provide easy access to these results at any time.		NR			
H	8.00	Print daily detailed master log of all work performed in lab for audit purposes.		NR			
H	9.00	Print list of received but untested samples due to insufficient quantity.		NR			
H	10.00	Display previous test's value, time, and date if delta check limit is exceeded during result entry.		NR			
H	11.00	Print list of all patient tests that require it (e.g. exceed delta check, panic values, and reference intervals).		NR			
H	12.00	Allow for cumulative result reporting. Please explain.		NR			
H	13.00	Includes features that allow batch reporting for phlebotomy, travel fees, microbiology no growths, and others.		NR			
H	14.00	Provide easy to set-up and use reflex rules (e.g. if TSH >5.5, then do a FT4).		NR			
H	15.00	Provide the date/time reported on reports transmitted by FAX, laser printer, and e-mail.		NR			
H	16.00	Provide a permanent log of all test results that have been edited.		NR			
H	17.00	Provide flexible reporting formats. Please explain.		NR			
		RULES-BASED LOGIC					
I	1.00	Ability for rules-based logic where laboratory personnel can define criteria in “if-then” statements.		NR			
I	2.00	Ability for Rules program to evaluate all rule entries for tests, not just the first one, so that complex or “cascading” rules may easily be designed, where several rules can be invoked based on one scenario.		NR			
I	3.00	Provide rules-based report routing.		NR			
I	4.00	Provide the ability to create rules to assist in decision support.		NR			

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I	5.00	Must have ability to flag results based on criteria other than standard reference ranges to include testing location, drawing location, ordering provider, patient age, and priority of order.		NR			
I	6.00	Charge rule capability.		NR			
		FLAGS AND DATA COMPARISON FOR TEST RESULTS					
J	1.00	Allow lab-defined age- and sex-related reference ranges for all test results.		NR			
J	2.00	Provide the ability to flag results based on criteria other than standard reference ranges.		NR			
J	3.00	Highlight abnormal results on patient reports without relying solely on color text.		NR			
J	4.00	Allow flagging of test results based on failed lab-defined delta checks.		NR			
J	5.00	Flag routine orders when timed pick-up, stats, etc. are ordered, to prevent multiple sticks.		NR			
J	6.00	Provide a means for documenting critical results and critical result documentation; generate reports regarding critical results communicated.		NR			
		SAMPLE STATUS AND TRACKING					
K	1.00	Provide the ability to track patient samples throughout the testing process.		NR			
K	2.00	Provide identification of the individual who ordered the test, collected the sample, and released the test results, including the date and time of these occurrences so that this information is accessible throughout the process.		NR			
K	3.00	Support user-defined priorities.		NR			
K	4.00	Support a way to identify the phlebotomist, (doctor, nurse, etc.) in system for samples not drawn by laboratory personnel.		NR			
K	5.00	Include data for tracing order (dates, times, tech ID, results) from order entry to final reporting in master log.		NR			
K	6.00	Provide index to master log by accession number.		NR			
		MEDICATION FOR PATIENTS					

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L	1.00	Ability to create electronic prescriptions and refills with accurate, up-to-date, drug specific information		NR			
L	2.00	Please describe the system's flexibility with electronic prescriptions (e.g. 1-click slection for RX, write or fax multiple prescriptions, etc…)		NR			
L	3.00	Ability to inferface with local pharmacies (HL7)		NR			
L	4.00	Provide automated alerts for medication recalls and current guidance on actions/follow-up needed by clinican		NR			
L	5.00	Describe how the system tracks medications dispensed, administered, and/or delivered to patients		NR			
L	6.00	Describe how the system crosschecks medications for incompatibility		NR			
L	7.00	Provide up-to-date dosage and treatment guidelines for most commonly diagnosed conditions		NR			
L	8.00	Please describe system's ability to provide prescription information to Non-English Speakers. Please include specific languages available.		NR			
		EDUCATION FOR PATIENTS					
M	1.00	Please describe system's ability to allow the user to access medical reports on health conditions, risk factors, diagnostic tests, etc..		NR			
M	2.00	Please describe system's ability to provide health education information to Non-English Speakers. Please include specific languages available.		NR			
		PATIENT RECORDS					
N	1.00	Maintain patient databases and provide ability to easily generate historical patient reports.		NR			
N	2.00	Allow patient database search based on:					
N	2.01	Patient name		NR			
N	2.02	Patient account number		NR			
N	2.03	Patient SSN		NR			
N	2.04	Patient phone number		NR			

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Reference Number		Functional Requirements	Response	Answer Submitted	Module(s)/Sub-module(s) Required to Fulfill Requirements	Assumptions	Comments
N	2.05	Date of Birth		NR			
N	2.06	Health insurance card number		NR			
N	2.07	Accession Number		NR			
N	2.08	Date of Service/Patient visit		NR			
N	3.00	Allow the user to search previous patient results for specific tests and easily view historical results of that test.		NR			
N	4.00	Allow the user to graph patient results by test to identify possible trends.		NR			
N	5.00	Allow historical results for multiple tests to be graphed on one normalized graph.		NR			
N	6.00	Allow the user to easily access archived patient records.		NR			
N	7.00	Allow the user to review specific patient's results without paging through the entire list of patient results.		NR			
		DOCUMENT MANAGEMENT AND IMAGING					
O	1.00	Allow users to populate state and federal forms using templates for recreating forms exacly in order to print and report to outside agencies		NR			
O	2.00	Provides users with easy-to-use system tags or barcodes for tagging a variety of electronic images/documents for filing into the patients record		NR			
O	3.00	Provide a scanning solution for barcoding and scanning historical paper files into patient's electonic record		NR			
O	4.00	Allow for all forms to be directly saved from EMRS system or scanned in from a physical copy of the form		NR			
O	5.00	Allow dynamic/barcode indexing which automatically files the barcoded/tagged document into specific areas within the patient's file		NR			
O	6.00	Describe how the system will generate a Continuity of Care Record for exporting patient information to another provider/agency		NR			
O	7.00	Describe how the system handles a patient's Release of Information		NR			
O	8.00	Provides the user the ability to securely email or e-Fax any document within the patient's chart		NR			

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		REFERENCE LABORATORIES					
P	1.00	Allow HL7 interface with:					
P	1.01	Pyxis		NR			
P	1.02	Quest		NR			
P	1.03	LabCorp		NR			
P	1.04	CPL		NR			
P	2.00	Allow testing laboratory destination routing based on patient's payer contract.		NR			
P	3.00	Allow testing laboratory destination routing based on laboratory testing menu.		NR			
P	4.00	Provide ability to override specified destination for laboratory testing.		NR			
P	5.00	Differentiate sample type based upon in-house and reference lab requirements.		NR			
P	6.00	Provide bi-directional interfaces to clinical reference laboratories.		NR			
P	7.00	Provide ability to print lab-defined reference laboratory requisition.		NR			
P	8.00	Allow manual entry of reference laboratory test results (e.g. non-interfaced reference laboratories).		NR			
		OUTREACH					
Q	1.00	Provide a web-based outreach solution.		NR			
Q	2.00	Describe how your system provides secure access via the web.		NR			
Q	3.00	Provide a multi-level security system to ensure the confidentiality of all patient-related information and to control access to outreach functions and features.		NR			
Q	4.00	Allow for electronic notification of the physician's review of results.		NR			

Attachment A: Collin County Detailed Business Requirements

Functional Category: General Technical Requirements

F = Fully Provided Standard Functionality with No Setup Required
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R = Provided with Reporting Tool
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NA = Not Available

Reference Number		Functional Requirements	Response	Answer Submitted	Module(s)/Sub-module(s) Required to Fulfill Requirements	Assumptions	Comments
Q	5.00	Provide the ability to link physician group practice names with individual doctors in the practice.		NR			
Q	6.00	Provide practice level security.		NR			
Q	7.00	Provide customizable order entry screens and application windows with outreach client's specific needs.		NR			
Q	8.00	Provide data mining capability within outreach application for use on any web-based computer.		NR			
Q	9.00	Provide multiple electronic interfaces to various outreach client information systems.		NR			
		COMMUNICATION AND END USER TOOLS					
R	1.00	Please describe any messaging system used for e-mail, patient specific information, and test result notices to providers		NR			
R	2.00	Please describe any voice and/or handwriting recognition provided by the system		NR			
R	3.00	Allow Live Bookmarks for automatically tracking new downloads and/or updates from state and federal agencies		NR			
R	4.00	Allow end user to create and edit custom forms without requiring programming knowledge		NR			
		MANAGEMENT AND ADMINISTRATION					
S	1.00	Provide ability to create completion reports by date.		NR			
S	2.00	Provide ability to create billing summary reports by date.		NR			
S	3.00	Provide ability to create reports of failed medical necessity checks.		NR			
S	4.00	Provide ability to create cancelled test reports that include test name and reason for cancellation.		NR			
S	5.00	Provide for a customizable overdue report that would indicate tests such as urine cultures that become overdue at 4 days while blood cultures become overdue at 7 days and CBC overdue at 4 hours.		NR			
S	6.00	Provide ability to create turnaround time reports by date.		NR			
S	7.00	Provide a summary report for test usage over a user-definable period of time.		NR			

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Reference Number		Functional Requirements	Response	Answer Submitted	Module(s)/Sub-module(s) Required to Fulfill Requirements	Assumptions	Comments
S	8.00	Provide physician utilization report (e.g. number of tests requested by a physician).		NR			
S	9.00	Provide ability to print a list of draws that need to be performed.		NR			
S	10.00	Provide a number of standard, user-defined reports that come with initial installation (e.g. number of patients attended per hour, per day, per month, per staff member, etc…)		NR			
S	11.00	Allow for generation of daily, weekly, monthly, quarterly, and annual data summaries without manual collection of data		NR			
		DATA MINING & ANALYSIS					
T	1.00	Provide user-friendly report generator with graphical user interface based on criteria entered		NR			
T	2.00	Provide ability to create reports of previous day test results.		NR			
T	3.00	Provide ability to create critical test value report.		NR			
T	4.00	Provide ability to electronically document supervisory review of all critical values.		NR			
T	5.00	Provide ability to generate patient lists (with certain demographic data) who meet specific result criteria for public health reporting.		NR			
T	6.00	Provide ability to mine any field (textual or numerical) in the data base.		NR			
T	7.00	Provide ability to write queries using logic in great detail.		NR			
T	8.00	Support the use of commercially available tools for report generation.		NR			
T	9.00	Provide ability to save commonly performed searches.		NR			
T	10.00	Provide ability to store supply records.		NR			
T	11.00	Provide on-line help screens to assist novice users in all applications.		NR			
		WORKFLOW					
U	1.00	Please describe workflow engine		NR			

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Reference Number		Functional Requirements	Response	Answer Submitted	Module(s)/Sub-module(s) Required to Fulfill Requirements	Assumptions	Comments
U	2.00	Please describe the speed/response time of system's real time data searches		NR			
U	3.00	Provide customizable data tables which can be created and/or updated by users with no additional programming necessary		NR			
U	4.00	Allow user-generated queues based on selected criteria		NR			
U	5.00	Allow tickler files to be created by user which requires follow-up activity (e.g. patient missed appointments, yearly physicals, scheduled immunizations)		NR			
U	6.00	Allow real time/live work lists for users to work from (e.g. patients to be seen by outreach worker, patients who need to be called for results, etc…)		NR			
U	7.00	Please describe how users can link/correlate patients for a variey of purposes (e.g. billing, disease reporting, contact investigations, QA analysis etc...)		NR			
U	8.00	Workstations work independently of each other. Multiple functions can occur simultaneously without one party having to exit the system.		NR			
		PATIENT SCHEDULING MANAGEMENT					
V	1.00	Please describe the system's patient scheduler		NR			
V	2.00	Ability to locate first available appointment based on patient needs		NR			
V	3.00	Describe the system's web based portal features for patient scheduing (e.g. updating patient information, downloading forms, scheduling appointments, etc…)		NR			
V	4.00	Ability to monitor patient load to manage flow to available examination rooms and staff members		NR			
V	5.00	Provide real time scheduling updates to allow patients to be automatically assigned to next available staff member		NR			
V	6.00	Provide automated email and/or phone appointment reminders for patients. Please describe. See Attachment E, Sample #1		NR			
		PATIENT REGISTRATION & TRACKING					
W	1.00	Please describe the system's patient registration features and address how the system collects and/or alerts the user of the following information:					
W	1.01	Demographics		NR			
W	1.02	Allergies		NR			

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Reference Number		Functional Requirements	Response	Answer Submitted	Module(s)/Sub-module(s) Required to Fulfill Requirements	Assumptions	Comments
W	1.03	Health History		NR			
W	1.04	Procedures		NR			
W	1.05	Prescriptions		NR			
W	1.06	Consultations		NR			
W	1.07	Medication Alerts		NR			
W	1.08	Other Alerts		NR			
W	2.00	Provides duplication detection		NR			
W	3.00	Provides de-duplication features. Please explain		NR			
W	4.00	Provides digital photographs as part of patient identification		NR			
W	5.00	Provides digital signature via electronic signature pad as part of patient identification		NR			
W	6.00	Provides automated eligibility of programs/services based on data entered		NR			
W	7.00	Provide a forms management solution to incorporate paper and electronic documents into patient file at time of registratin (e.g. insurance cards, HIPAA consent forms, upload information entered by patient on web portal, etc…) Please explain		NR			
W	8.00	Provide patient dashboard for end user to readily see patient reminders/alerts on landing page		NR			
W	9.00	Provide real-time updates on patient wait time tracking (e.g. color-coded wait time alerts after specified minutes of wait time)		NR			
W	10.00	Provide time stamp of all steps/users in patient consultation to provide complete audit trail of patient visit		NR			
W	11.00	Provide real-time patient flow update and patient locator by allowing automatic refresh of patient status/location within the clinic		NR			
		FINANCIAL/PATIENT BILLING					

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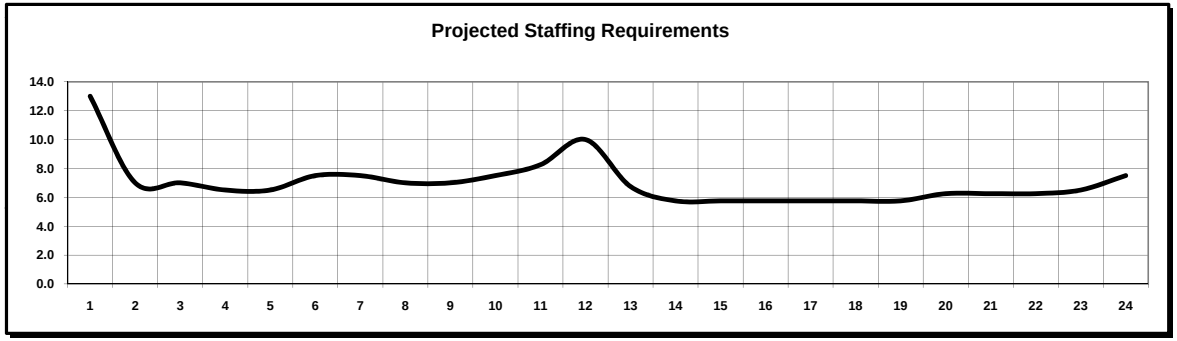
	Reference Number	Functional Requirements	Response	Answer Submitted	Module(s)/Sub-module(s) Required to Fulfill Requirements	Assumptions	Comments
X	1.00	Provide a web-based revenue solution to allow staff to print receipts, accept payments, and auto-post into EMRS		NR			
X	2.00	Please describe your financial component for Medicare and Medicaid (e.g. electronically billing to Medicare & Medicaid)		NR			
X	3.00	Ability to interface with existing AS400 financial system		NR			
X	4.00	Ability to integrate with Official Payments, Corp and Certified Payments, Inc. for online and point of sale payment processing		NR			
X	5.00	Provide real time eligibility		NR			
X	6.00	Ability to link clerical information to billing system so that items are billed/charged/posted as orders are generated during the visit		NR			
X	7.00	Ability to process paper and electronic claims with tracking capabilities to ensure timely proof of filing		NR			
X	8.00	Ability to create edits for claim scrubbing prior to submission in order to insure error-free claims submissions		NR			
X	9.00	Provide on-demand super-bill and forms for custom paper super-bill and/or electronic super-bill		NR			

Attachment B: Staffing Levels

Schedule 1 - SAMPLE
Estimated Client Staffing Levels

	Month																							
PROJECT ROLL-OUT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Phase I																								
Phase II																								
AREA/POSITION	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
CROSS-PHASE RESOURCES																								
Project Manager	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Technical Lead	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0.5	0.5	0.5	0.5	0.5	0.5	1.0
Change Management Leader	1.0	0.0	0.0	0.0	0.0	1.0	1.0	0.5	0.5	1.0	1.0	1.0	1.0	0.0	0.0	0.0	0.0	0.5	0.5	1.0	1.0	1.0	1.0	1.0
Total Cross-Phase FTE	3.0	2.0	2.0	2.0	2.0	3.0	3.0	2.5	2.5	3.0	3.0	3.0	3.0	2.0	2.0	2.0	2.0	2.0	2.0	2.5	2.5	2.5	2.5	3.0
PHASE I																								
GL SME	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.5	0.5	0.5	0.5	1.0
Budget SME	1.0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	1.0	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.5	1.0
AP SME	1.0	1.0	1.0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
AR SME	1.0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Purchasing SME	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Fixed Assets SME	1.0	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total for Phase I FTE	5.0	3.3	3.3	2.8	2.8	2.8	2.8	2.8	2.8	2.8	3.3	4.0	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.5	1.0
PHASE II																								
Fixed Assets SME	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Inventory SME	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Total for Phase II FTE	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
TECHNICAL SUPPORT																								
Database Administrator	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Network Administrator	1.0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	1.0	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Software Engineer	1.0	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.5	1.0	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Total Technical Support FTE	3.0	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	2.0	3.0	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
Total Projected FTE By Month	13.0	7.0	7.0	6.5	6.5	7.5	7.5	7.0	7.0	7.5	8.3	10.0	6.8	5.8	5.8	5.8	5.8	5.8	5.8	6.3	6.3	6.3	6.5	7.5
Variance by Month	0	-6	0	-1	0	1	0	-1	0	1	1	2	-3	-1	0	0	0	0	0	1	0	0	0	1

Assumptions:

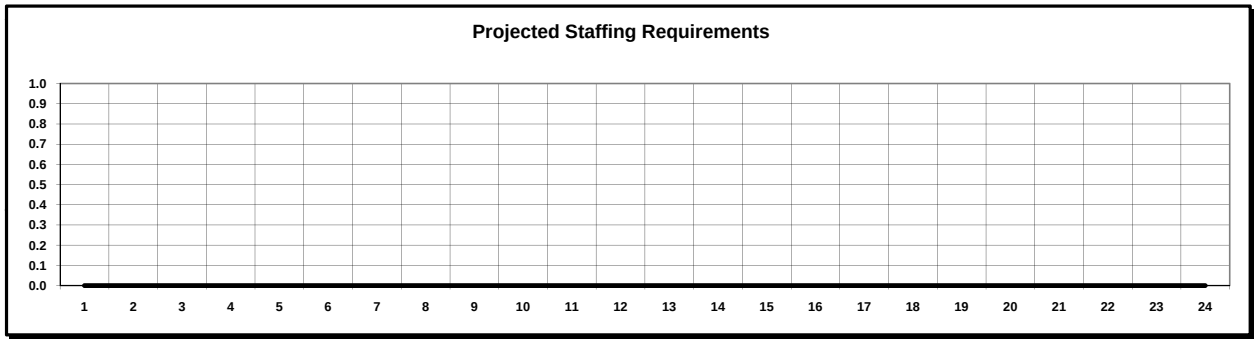


Attachment B: Staffing Levels

Schedule 2
Estimated County Staffing Levels

	Month																							
PROJECT ROLL-OUT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
	2010								2011															
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec				
AREA/POSITION	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
CROSS-PHASE RESOURCES																								
Total Cross-Phase FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PHASE I																								
Total for Phase I FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PHASE II																								
Total for Phase II FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TECHNICAL SUPPORT																								
Total Technical Support FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Projected FTE By Month	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Variance by Month	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Assumptions:
Respondent assumes most configuraton duty Couny SME provides guidance, oversight and rough order acceptance.

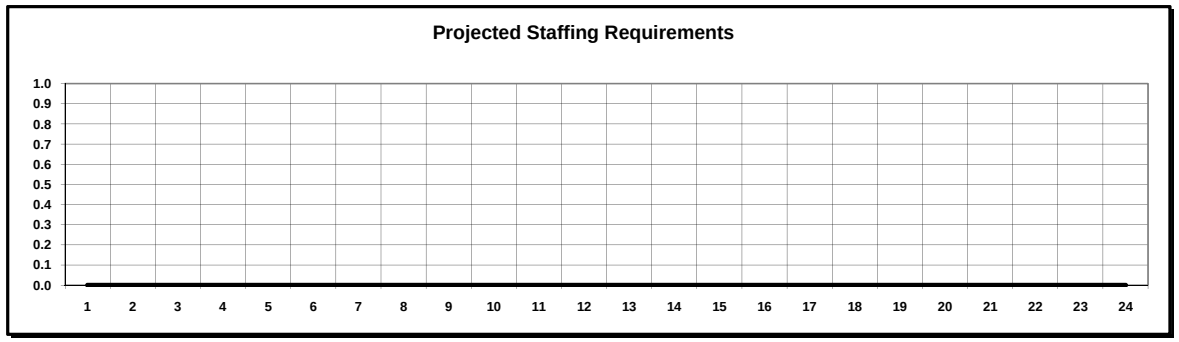


Attachment B: Staffing Levels

Schedule 2
Estimated Consultant Staffing Levels

	Month																							
PROJECT ROLL-OUT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
	2010								2011															
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Dec			
AREA/POSITION	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
CROSS-PHASE RESOURCES																								
Total Cross-Phase FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PHASE I																								
Total for Phase I FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PHASE II																								
Total for Phase II FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TECHNICAL SUPPORT																								
Total Technical Support FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Projected FTE By Month	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Variance by Month	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Assumptions:
Respondent assumes most configuraton duty
County SME provides guidance, oversight and rough order acceptance.
County resources available Tue - Thur.
Months 7, 13 and 19 represent go-live options



Attachment C: Proposed Cost Schedule

Schedule 1: Summary

Summary of Total Software, Professional Services, and Maintenance Costs

Cost Categories	Proposed Cost in RFP	Explanation/Notes (if necessary)**
Software License Fees (Schedule 2)(*)(**)		
Professional Services (Schedules 3, 4, & 5):		
Implementation Services (Schedule 3)		
Data Conversion and Interfaces Estimate (Schedule 3)		
Training (Schedule 4)		
Travel and Other Costs (Schedule 5)		
Hardware Costs (if any)		
Total Cost During Project Period	**$ -**	

Ongoing Maintenance & Support (Years 1-5)

Period	Proposed Cost in RFP	Explanation/Notes (if necessary)**
Year One*		
Year Two		
Year Three		
Year Four		
Year Five		

Please identify the time at which "Year One" support begins (e.g., once software goes into production).

****Attach additional notes (if needed) to provide full explanation.***

Assumptions/Additional Comments

List here the maintenance & support starting point (e.g., 10% of license) and annual caps in growth (e.g., lower of x% per year or inflation). Also list all other assumptions and use additional space if necessary.

Please check all cell formulas!!

Attachment C: Proposed Cost Schedule

Schedule 2: Licensing Fees

Detailed Licensing Fees By Module

Module	Proposed Cost in RFP	Number of Users/Employees	Fee Per User/Employee	Explanation/Notes (if necessary)**
Subtotal	***$ -***			
Third-Party Software (List Individually)				
Subtotal	***$ -***			
Pre-Requisite Software (List Individually)				
Subtotal	***$ -***			
List Price	**$ -**			
Discountable Software				
Less Discount				
Total License Fees				

Attach additional notes (if needed) to provide full explanation.

Assumptions/Additional Comments

List all other assumptions here.

Please check all cell formulas!!

Attachment C: Proposed Cost Schedule

Schedule 3: Professional Services

Estimated Professional Services By Implementation Phase

1. Estimated Vendor Hours and Cost

Activity / Phase	Data Conversion			Interfaces			All Other Implementation Services			Total	
	Hours	Rate*	Cost	Hours	Rate*	Cost	Hours	Rate*	Cost	Hours	Cost
Design										0	$ -
Configure										0	$ -
Build										0	$ -
Deploy										0	$ -
Change Management										0	$ -
(add additional cells if needed)										0	$ -
Total	0		$ -	0		$ -	0		$ -	0	$ -

** Please use (and specify) the proposed blended rate for each phase.*

2. Assumed Government Hourly Participation (Please input the estimated "Hours" only)

Activity / Phase	Data Conversion			Interfaces			All Other Implementation Services			Total	
	Hours	Rate*	Cost	Hours	Rate*	Cost	Hours	Rate**	Cost	Hours	Cost
Design											
Configure											
Build											
Deploy											
Change Management											
(add additional cells if needed)											
Total	0.00			0.00			0.00			0.00	

Assumptions/Additional Comments

Please check all cell formulas!!
Respondents proposing to implement in multiple phases must identify any project phases in this section.

Attachment C: Proposed Cost Schedule

Schedule 4: Training Costs
Estimated Cost of Training by Phase

1. Training Hours and Costs By Trainee

Phase / Trainee Type	Number of Students	Project Team			Functional SME			Med/Heavy User			Inquiry Only			Other			Total	
		Units	Cost/Unit	Cost	Units	Cost/Unit	Cost	Units	Cost/Unit	Cost	Units	Cost/Unit	Cost	Units	Cost/Unit	Cost	Units	Cost
Total	0	0		$0	0		$0	0		$0	0		$0	0		$0	0	$0

Please label each Phase to be consistent with your implementation methodology.

2. Additional Training Costs

Phase / Type		Project Team			Functional SME			Med/Heavy User			Inquiry Only			Other			Total	
		Units	Cost/Unit	Cost	Units	Cost/Unit	Cost	Units	Cost/Unit	Cost	Units	Cost/Unit	Cost	Units	Cost/Unit	Cost	Units	Cost
Total	0	0		$0	0		$0	0		$0	0		$0	0		$0	0	$0

3. Total Training Costs

Phase / Total Cost		Project Team			Functional SME			Med/Heavy User			Inquiry Only			Other			Total	
				Cost			Cost			Cost			Cost			Cost		Cost
Total Cost		0		$0	0		$0	0		$0	0		$0	0		$0	0	$0

Assumptions/Additional Comments

Note: Phases are provided for illustration purposes only. Cost submittal must match any phases proposed in implementation plan.

Please check all cell formulas!!

Attachment C: Proposed Cost Schedule

Schedule 5: Travel & Other Costs

Travel and Other Costs

Phase / Category	Phase I	Phase II	Phase III	Phase IV	Phase V	Total
	Cost	Cost	Cost	Cost	Cost	Cost
Total	$ -	$ -	$ -	$ -	$ -	

The County assumes that only one implementation phase will be proposed. Please label each Phase to be consistent with your implementation methodology if proposing multiple implementation phases.

Assumptions/Additional Comments

Please check all cell formulas!!

******FEE SCHEDULE*****

Patient Name: _____ Date: _____

Appointment Time: _____ AM PM Arrived Time: _____ AM PM

TB
☐ DOT $ 0
☐ New Patient Office Visit $ 20
☐ Office Visit $ 2 per √
☐ Medications $ 2 per √
☐ Liver Profile $ 2 per √
☐ Civil Surgeon Clearance
☐ Office Visit $ 90
☐ Follow-Up Visit $ 13
☐ Chest X-Ray $ 35
☐ Labs $ 80

Komen
☐ Office Visit
☐ Follow-Up Visit

STD
☐ New Patient Office Visit $ 20
☐ Follow-Up Visit $ 10
☐ Labs $ 10
☐ Medication ☐ $ 5 ☐ $ 10
☐ Herpes ☐ $ 50 ☐ $ 100
☐ Test Results
☐ Immunizations

Employee Health
☐ New Patient Office Visit
☐ Follow-Up Visit
☐ Sick Visit
☐ POPP
☐ Immunizations
☐ DOT Exam
☐ Labs
☐ Other

Well Women
☐ Office Visit
☐ Follow-Up Visit
☐ State Employee Co-Pay $ 20

Dr. Pho / Indigent
☐ New Patient Office Visit
☐ Follow-Up Visit
☐ Employee
☐ Labs
☐ Other

Return Appointment Date & Time: _____

COLLIN COUNTY HEALTH CARE SERVICE FORM

Patient Name: _____ Date: _____

Appt. Time _____

Arrived Time _____

TB Clinic:

- ☐ DOT $0
- ☐ New Pt. Office Visit $20
- ☐ Office Visit $2per √
- ☐ Medications $2per √
- ☐ Liver Profile $2per √

Komen Clinic:

- ☐ Office Visit
- ☐ Follow-up

Well Women Clinic:

- ☐ Office Visit
- ☐ Follow-up
- ☐ State Employee Co-pay $20

STD Clinic:

- ☐ New Pt. Office Visit $20
- ☐ Follow-up $10
- ☐ Labs $ 10

Medication

☐ $5 ☐ $10

Herpes

☐ $50 ☐ $100

RETURN APPT. DATE & TIME:

_____

COLLIN COUNTY HEALTH CARE SERVICES

ACKNOWLEDGMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

I understand that as part of the provisions of healthcare services. Collin County creates and maintains health records and other information describing, among other things, my health and medical history, symptoms, examination and test results, diagnose, treatment and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that Collin County reserves the right to change its Notice and practices with regard to the use and disclosure of health information. I understand that I have the right to request restrictions as to how my health information may be used or disclosed for treatment, payment, or healthcare operations, but that Collin County is not required to agree to the request restrictions.

_____ _____
Name (PRINTED) Date

_____
Signature (Guardian if patient is minor)

NOTIC . PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

If you have any questions about this Notice please contact: Candy Blair by calling 972 548-5532.

We are required by law to maintain the privacy of protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by either mailing the revised Notice to an address you provide or by delivering a revised Notice to you at our office.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and Disclosures of Protected Health Information for Treatment, Payment and Health Care Operations

We are permitted to use and disclose your protected health information for treatment, payment and health care operations as described in this Section 1. Your protected health information may be used and disclosed by us and others outside of our office that are involved in your care and

services to you. Your protected health information may also be used and disclosed to facilitate payment of your health care bills and to support our operations.

Following are examples of the types of uses and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians and health care providers who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at our request, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your protected health information may be used, as needed, to obtain payment for your health care services. This may include certain activities that a payor (whether a governmental entity or private insurance or other health plan) may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our office. These activities include, but are not limited to: quality assessment activities; employee review activities; training of medical students, other practitioners, or non-health care professionals; accreditation; certification; licensing; credentialing; and conducting or arranging for other business activities. For example, we may use and disclose your protected health information when training and reviewing our staff.

We may use or disclose your protected health information, as necessary, to contact you to remind you of upcoming appointments.

We will share your protected health information with third party "business associates" that perform various activities (e.g., auditing, legal) for us. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. This requirement will not apply if the business associate is a "health care component" designated by our governing body.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services we offer that may be of interest to you. You may contact our Privacy Official to request that these materials not be sent to you.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation.

Other Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted Uses and Disclosures to Which You May Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are not

DOCUMENT USED IN ALL CC CLINICS*

present or unable to agree or object to such a disclosure because of [illegible] incapacity or an emergency circumstan[illegible] may disclose such information as necessa[illegible] determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. If required by law, you will be notified of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Abuse or Neglect: We may disclose your protected health information to a public health authority or other government authority that is authorized by law to receive reports of child abuse or neglect. In addition, if we believe that you have been a victim of abuse, neglect or domestic violence we may disclose your protected health information to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Health Oversight: We may disclose protected health information to a health oversight agency for

activities authorized by law, such as audits, investigations, ar ...spections. Oversight agencies seeking ...rmation include government agenc... ...t oversee the health care system, ...overnment benefit programs, other government regulatory programs and civil rights laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biological product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in response to a subpoena, discovery request or other lawful process as permitted by law.

Law Enforcement: We may disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. Such disclosures include (1) the reporting of certain physical injuries; (2) responding to legal processes; (3) providing limited information for identification and location purposes, (4) providing law enforcement officials with information pertaining to victims of a crime; (5) reporting deaths possibly resulting from criminal conduct; (6) reporting a crime that occurs on our premises; and (7) reporting criminal activity outside our premises that results in emergency medical services.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

DOCUMENT USED IN ALL CC CLINICS

Serious Threat to Health or Safety: Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or certain other individuals.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and we created or received your protected health information in the course of providing care to you.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Title 45, Code of Federal Regulations, Parts 160 and 164.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your ...e or for notification purposes as described in ...otice of Privacy Practices. Your request ...tate the specific restriction requested and to w... you want the restriction to apply.

We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If we agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your health care provider. You may request a restriction by completing a "Restriction of use and Disclosures Request Form," which you may obtain from our Privacy Official.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Official.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that we use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to any law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. Please contact our Privacy Official if you have questions about access to your medical record.

You may have the right to have us amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. Requests for amendment must be in writing and must provide a reason to support each requested amendment. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your stater... and will provide you with a copy of any such ret... ...ase contact our Privacy Official if you have ...ions about amending your protected health info... ...n.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, for notification purposes, and for other purposes, as permitted by law. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003 and during the six years prior to your request. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the person named below of your complaint. We will not retaliate against you for filing a complaint.

For further information about the complaint process, or to file a complaint, contact:

Candy Blair
825 N McDonald 130
McKinney TX 75069
Phone 972 548-5532
Fax 972 548-5550

For further information about filing a complaint with the Secretary of Health and Human Servers, or to file a complaint, contact:

U.S. Department of Health and Human Services, Office for Civil Rights
Medical Privacy, Complaint Division
200 Independence Avenue, SW
HHH Building, Room 509H
Washington, D.C. 20201
Phone: 866-627-7748
TTY: 886-788-4989

This notice was published and becomes effective on April 14, 2003.

NOTICE OF PRIVACY PRACTICES – HEALTH CARE PROVIDERS
Effective April 14, 2003

COLLIN COUNTY HEALTH CARE SERVICES

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby request and authorize Collin County Health Care to release and disclose the protected health information listed below to the following entity:

Name: _____
(Physician, Hospital, Clinic, Health Department, and/or Region)

Address: _____

Phone#: _____ Fax#: _____

Purpose of Disclosure: _____

Patient Information:

Name: _____ DOB: ____/____/____ SSN: _____

Address: _____

_____

This request and authorization extends to only documents containing the following information:

_____ All information pertaining to Patient

_____ All medical information pertaining to Patient

_____ All non-medical information pertaining to Patient

_____ Only Statements of charges or payments

_____ Only information pertaining to the following condition, injury or treatment: _____

_____

_____ Other *(specify)* _____

This authorization is freely given with the understanding that:

1. Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law.
2. A photocopy or facsimile of this authorization is as valid as the original.
3. I may revoke this authorization at any time. However, the revocation shall not apply to information previously released in reliance on this authorization.
4. This authorization is valid for the duration of patient's eligibility for the indigent program.
5. Collin County and its officers and employees are hereby released from any legal responsibility and liability for disclosure of the information as noted above if disclosure is in accordance with this authorization.
6. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
7. I understand that treatment and payment are not a condition of signing this authorization. I may receive a copy of this form after I have signed it.

_____	_____	_____
Patient Name (PRINTED)	Date	Patient's / Guardian's Signature

_____	_____
Legal Relationship to Patient *(Same Parent, Guardian, etc.)*	Social Security Number of Signer

(IHCP Coincides with Patient's Eligibility)
Revocation Date (if other than 60 days)
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
Effective April 14, 2003

COLLIN COUNTY HEALTH CARE SERVICES

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

hereby request and authorize _____ to release and disclose the
(Physician, Hospital, Clinic, Health Department, and/or Region)
protected health information listed below to the following entity.

Collin County Health Care
825 N. McDonald St. Ste.130
McKinney, TX. 75069
Phone: (972)-548-5532 or Metro: (972)-424-1460 ext. 5532
Fax: (972)-548-5550

Purpose of Disclosure: _____

Patient Information:

Name: _____ DOB: ____/____/____ SSN: _____

Address: _____

_____

This request and authorization extends to only documents containing the following information:

_____ All information pertaining to Patient

_____ All medical information pertaining to Patient

_____ All non-medical information pertaining to Patient

_____ Only Statements of charges or payments

_____ Only information pertaining to the following condition, injury or treatment: _____

_____

_____ Other *(specify)* _____

This authorization is freely given with the understanding that:

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3. I may revoke this authorization at any time. However, the revocation shall not apply to information previously released in reliance on this authorization.
4. This authorization is valid for the duration of patient's eligibility for the indigent program.
5. _____ is hereby released from any legal responsibility and
(Physician, Hospital, Clinic, Health Department, and/or Region)
liability for disclosure of the information as noted above if disclosure is in accordance with this authorization.
6. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
7. I understand that treatment and payment are not a condition of signing this authorization. I may receive a copy of this form after I have signed it.

_____	_____	_____
Patient Name (PRINTED)	Date	Patient's / Guardian's Signature

_____	_____
Legal Relationship to Patient *(Same Parent, Guardian, etc.)*	Social Security Number of Signer

(IHCP Coincides with Patient's Eligibility)
Revocation Date (if other than 60 days)
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
Effective April 14, 2003

DOCUMENT USED IN :
CC EMPLOYEE HEALTH

COLLIN COUNTY HEALTH CARE SERVICES

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby request and authorize Collin County Health Care Services to release and disclose the protected health information listed below to the following entity:

Name: _____
(Physician, Hospital, Clinic, Health Department, and/or Region)

Address: _____

Phone#: _____ **Fax#:** _____

Purpose of Disclosure: _____

Patient Information:

Name: _____ **DOB:** ____/____/____ **SSN:** _____

Address: _____

This request and authorization extends to only documents containing the following information:

_____ All information pertaining to Patient

_____ All medical information pertaining to Patient

_____ All non-medical information pertaining to Patient

_____ Only Statements of charges or payments

_____ Only information pertaining to the following condition, injury or treatment: _____

_____

_____ Other (specify) _____

This authorization is freely given with the understanding that:

1. Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law.
2. A photocopy or facsimile of this authorization is as valid as the original.
3. I may revoke this authorization at any time. However, the revocation shall not apply to information previously released in reliance on this authorization.
4. This authorization is valid for the duration of patient's eligibility for the indigent program.
5. Collin County and its officers and employees are hereby released from any legal responsibility and liability for disclosure of the information as noted above if disclosure is in accordance with this authorization.
6. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
7. I understand that treatment and payment are not a condition of signing this authorization. I may receive a copy of this form after I have signed it.

_____	_____	_____
Patient Name (PRINTED)	**Date**	**Patient's / Guardian's Signature**

_____	_____
Legal Relationship to Patient *(Same Parent, Guardian, etc.)*	**Social Security Number of Signer**

(IHCP Coincides with Patient's Eligibility)
Revocation Date (if other than 60 days)
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
Effective April 14, 2003

DOCUMENT USED IN :
CC EMPLOYEE HEALTH

COLLIN COUNTY HEALTH CARE SERVICES

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby request and authorize _____ to release and disclose the
(Physician, Hospital, Clinic, Health Department, and/or Region)
protected health information listed below to the following entity.

Collin County Health Care
825 N. McDonald St. Ste.130
McKinney, TX. 75069
Phone: (972)-548-5532 or Metro: (972)-424-1460 ext. 5532
Fax: (972)-548-5550

Purpose of Disclosure: _____

Patient Information:

Name: _____ DOB: _____/_____/_____ SSN: _____

Address: _____

This request and authorization extends to only documents containing the following information:

_____ All information pertaining to Patient

_____ All medical information pertaining to Patient

_____ All non-medical information pertaining to Patient

_____ Only Statements of charges or payments

_____ Only information pertaining to the following condition, injury or treatment: _____

_____

_____ Other *(specify)* _____

This authorization is freely given with the understanding that:

1. Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law.
2. A photocopy or facsimile of this authorization is as valid as the original.
3. I may revoke this authorization at any time. However, the revocation shall not apply to information previously released in reliance on this authorization.
4. This authorization is valid for the duration of patient's eligibility for the indigent program.
5. _____ is hereby released from any legal responsibility and
   (Physician, Hospital, Clinic, Health Department, and/or Region)
   liability for disclosure of the information as noted above if disclosure is in accordance with this authorization.
6. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
7. I understand that treatment and payment are not a condition of signing this authorization. I may receive a copy of this form after I have signed it.

_____	_____	_____
Patient Name (PRINTED)	**Date**	**Patient's / Guardian's Signature**

_____	_____
Legal Relationship to Patient *(Same Parent, Guardian, etc.)*	**Social Security Number of Signer**

(IHCP Coincides with Patient's Eligibility)
Revocation Date (if other than 60 days)
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
Effective April 14, 2003

DOCUMENT USED IN :
CC EMPLOYEE HEALTH

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

RELEASE OF RESPONSIBILITY

_____ _____
NAME OF PATIENT DATE / TIME

_____ _____
PATIENT DATE OF BIRTH PATIENT SOCIAL SECURITY #

I HEREBY REFUSE DOCTOR VISIT FOR: _____

I HEREBY REFUSE BLOOD DRAW FOR: _____

I HEREBY REFUSE TREATMENT FOR: _____

I HEREBY REFUSE MEDICATIONS LISTED: _____

OTHER: _____

I ACKNOWLEDGE THAT THE ABOVE HAS BEEN EXPLAINED AND DESPITE THE POSSIBLE BENEFITS OF DIAGNOSIS AND/OR TREATMENT, I REFUSE TO ACCEPT THE ABOVE RECOMMENDATION. I UNDERSTAND THAT MY REFUSAL MAY RESULT IN A LOSS OF AN OPPORTUNITY FOR EARLY DIAGNOSIS AND A CURE.

_____ _____
PATIENT SIGNATURE DATE / TIME

_____
WITNESS

THE AFOREMENTIONED PATIENT HAS REFUSED THE ABOVE LISTED ATTENTION AND HAS REFUSED TO SIGN THIS FORM.

_____ _____
WITNESS DATE / TIME

DOCUMENT USED IN :
CC EMPLOYEE HEALTH

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

_____ _____ _____
Name DOB Date

1. During the Department of Transportation (DOT) physical exam for Collin County the following medical issues were noted:

_____

_____

_____

_____

2. This clinic will need a letter from your physician(s) addressing the following:

a) _____

b) _____

c) _____

d) _____

e) _____

f) _____

3. The letter must be on the physician's letterhead and include the following items:
   a. Diagnosis
   b. Treatment
   c. Outcome of treatment
   d. Disability if any

4. The original letter must be mailed to the above address, and in addition, it may also be faxed or carried back to the clinic.

Attention: Michael Hale, PA-C / Muriel Marshall, DO
Secure Fax: 972-547-1823/972-548-4396

DOCUMENT USED IN :
CC EMPLOYEE HEALTH

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

Date_____

Dear_____,

We are writing to inform you that your Department of Transportation card has been issued. Please carry this card with you at all times. However, further evaluation and consideration of treatment is needed with regard to the following issue(s):

1) Blood pressure exceeds the DOT requirement (140/90).

2) Elevated blood sugar

3) Other, as specified: _____

Please provide documentation within _____ from your treating physician that the above referenced matter is being addressed and monitored. Thank you for your attention to this important health issue.

Sincerely,

Michael Hale, PA-C/Muriel Marshall, D.O.

Please provide documentation to the following address:

Collin County Employee Health Clinic
825 N. McDonald St. Ste. 130
McKinney, TX. 75069
Fax: 972-548-4396

DOCUMENT USED IN :
CC EMPLOYEE HEALTH

COLLIN COUNTY EMPLOYEE HEALTH
N-95 TB RESPIRATOR MASK FIT QUESTIONNAIRE

DATE:_____

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (Please Print).

Name_____ SSN_____
Age_____ Sex Male Female Height _____ Weight_____lbs.
Dept._____ Job Title_____ Ext.___

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1.	Do you currently smoke tobacco, or have you smoked tobacco in the last month?		yes	no
2.	Have you ever had any of the following conditions?			
	a.	Seizures	yes	no
	b.	Diabetes	yes	no
	c.	Allergic reactions that interfere with your breathing	yes	no
	d.	Claustrophobia	yes	no
	e.	Trouble smelling odors	yes	no
3.	Have you ever had any of the following pulmonary or lung problems?			
	a.	Asbestosis	yes	no
	b.	Asthma	yes	no
	c.	Chronic Bronchitis	yes	no
	d.	Emphysema	yes	no
	e.	Pneumonia	yes	no
	f.	Tuberculosis	yes	no
	g.	Silicosis	yes	no
	h.	Pneumothorax	yes	no
	i.	Lung Cancer	yes	no
	j.	Broken Ribs	yes	no
	k.	Any chest injuries or surgeries	yes	no
	l.	Any other lung problems that you've been told about	yes	no
4.	Do you currently have any of the following symptoms of pulmonary or lung illness?			
	a.	Shortness of breath	yes	no
	b.	Shortness of breath when walking fast on level ground or walking up a slight hill or incline	yes	no
	c.	Shortness of breath when walking with other people at an ordinary pace on level ground	yes	no
	d.	Have to stop for breath when walking at your own pace on level ground	yes	no
	e.	Shortness of breath when washing or dressing yourself	yes	no
	f.	Shortness of breath that interferes with your job	yes	no
	g.	Coughing that produces phlegm	yes	no
	h.	Coughing that wakes you early in the morning	yes	no

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CC EMPLOYEE HEALTH

N-95 TB RESPIRATOR MASK FIT QUESTIONNAIRE

i.	Coughing that occurs mostly when you are lying down	yes	no
j.	Coughing up blood in the last month	yes	no
k.	Wheezing	yes	no
l.	Wheezing that interferes with your job	yes	no
m.	Chest pain when you breathe deeply	yes	no
n.	Any other symptoms that you think may be related to lung problems	yes	no

5. Have you ever had any of the following cardiovascular or heart problems?

a.	Heart Attack	yes	no
b.	Stroke	yes	no
c.	Angina	yes	no
d.	Heart Failure	yes	no
e.	Swelling in your legs or feet (not caused by walking)	yes	no
f.	Heart arrhythmia	yes	no
g.	High blood pressure	yes	no
h.	Any other heart problem that you've been told about	yes	no

6. Have you ever had any of the following cardiovascular or heart symptoms?

a.	Frequent pain or tightness in your chest	yes	no
b.	Pain or tightness in your chest during physical activity	yes	no
c.	Pain or tightness in your chest that interferes with your job	yes	no
d.	In the past two years, have you noticed your heart skipping or missing a beat	yes	no
e.	Heartburn or indigestion that is not related to eating	yes	no
f.	Any other symptoms that you think may be related to heart or circulation problems	yes	no

7. Do you currently take medication for any of the following problems?

a.	Breathing or lung problems	yes	no
b.	Heart trouble	yes	no
c.	Blood pressure	yes	no
d.	Seizures	yes	no

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, skip this question and to question 9)

a.	Eye irritation	yes	no
b.	Skin allergies or rashes	yes	no
c.	Anxiety	yes	no
d.	Seizures	yes	no

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? yes no

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CC EMPLOYEE HEALTH

If the entire test is completed without the subject detecting the taste of aerosol, the test is successful and the respirator is deemed adequate.

Confirmation of Fit Testing and Questionnaire

Date:_____

Name:_____

Signature:_____

Department:_____

Tested By:_____

Fit testing was performed by using the N-95 Particulate Respirator

Respirator size to be used:_____

DOCUMENT USED IN :
CC EMPLOYEE HEALTH

Fit Testing Protocol

Name:_____ **Date:**_____

TASTE THRESHOLD SCREENING

1. Test subject has not eaten or chewed gum 15 minutes before test.
2. Test subject places hood overhead.
3. Test subject through open mouth with tongue extended.
4. Test conductor shall spray of the Threshold Check Solution into the hole in the hood. And record the appropriate number of sprays.
   a. 10 units
   b. 20 units
   c. 30 units
5. If the saccharin is not tasted after 30 units, the test subject may not proceed to the fit testing stage.
6. If a taste response is elicited, the test subject shall be instructed to remember the taste for reference in the fit testing stage.

   Pass **Fail**

FIT TESTING

1. Test subject rinses mouth and waits several minutes.
2. Test subject fits the N-95 mask around the mouth and nose checking for a tight fit and places the hood overhead.
3. The test subject shall spray the Taste Threshold Solution into the hole in the hood.
   a. 10 units
   b. 20 units
   c. 30 units
4. The test conductor shall instruct the test subject to:
   a. Normal breath
   b. Deep breath
   c. Turn head from side-to-side and inhale when head is at side.
   d. Have test subject read passage below out loud.
   e. Every 30 seconds the fit test subject shall be replenished ½ the number of squeezes initially needed to pass the Fit Test Procedure.
   f. Test subject shall indicate to the test conductor if at any time during the testing the taste of Saccharin is detected.

   Pass **Fail**

Test Conductors Signature:_____ **Date:**_____

DOCUMENT USED IN :
CC EMPLOYEE HEALTH

COLLIN COUNTY EMPLOYEE CLINIC
Tuberculosis Annual Screening

NAME: _____

SS #:_____DATE_____

TST

Date given: _____ Results: _____mm

Placed on medication: YES NO

Length of time on Medication? _____

CHEST X-RAY

Date _____ Results: _____

Comments:

Recommended repeat chest x-ray Date: _____

QUANTIFERON GOLD

Date of Lab_____ Results: _____

Recommended repeat serology Date_____

LAB REQUEST FORM

Collin County

LABORATORY STUDIES

☐ EMPLOYEE HEALTH ☐ INDIGENT

TEST	CPL CODE
☐ ACUTE HEPATITIS PANEL (HEP A IgM, anti-HBs, Igm, HBsAg, Hep C ANTIBODY)	9325
☐ HEPATITIS ABC (HEP A IgM, anti-HBc, Igm, HBsAg, Hep C ANTIBODY, anti-HBs-Quantitative)	162
☐ ANA	3550
☐ BMP	142
☐ CARBAMAZEPINE (TEGRETOL)	3025
☐ CBC	1000
☐ CK, TOTAL	2075
☐ CMP	9179
☐ CMV IgG/IgM	4543
☐ C-REACTIVE PROTEIN, Hi-sen	5083
☐ DIGOXIN	3034
☐ FERRITIN	2090
☐ FOLIC ACID	2695
☐ GEN. HEALTH (CBC, CMP, TSH)	9329
☐ HEP. A TOTAL AB	2724
☐ HEP. Bs AB QUAN.	2738
☐ HEP C ANTIBODY	4675
☐ HIV	3540
☐ Hgb A1c	2708
☐ LIPID PANEL	173
☐ LIVER FUNCTION TEST	9175
☐ MUMPS IgG	4585
☐ PHENYTOIN (DILANTIN)	3064
☐ PROLACTIN	2800
☐ PSA	2606
☐ PT	1425
☐ PTT	1430
☐ RABIES AB/TITER	4597
☐ RA LATEX	3505
☐ RUBELLA	4600
☐ RUBEOLA	4604
☐ IRON	2222
☐ SED RATE	1055
☐ SICKLE CELL SCREENING	3520
☐ T3	2817
☐ T4	2819
☐ THROAT CULTURE	6046
☐ THYROID PROFILE	119
☐ TSH	2835
☐ UA WITH MICRO	1510
☐ URINE CULTURE	6049
☐ VARICELLA	4665
☐ VITAMIN B-12	2840
☐ VITAMIN C	4958
☐ VITAMIN D-25 OH	4958
☐ OTHER:_____	
☐ OTHER:_____	
☐ OTHER:_____	

DOCUMENT USED IN : CC EMPLOYEE HEALTH

IN HOUSE TESTING

☐ FSBS	_____MG/dL		N/A
☐ PREG. TEST	(+)	(-)	N/A
☐ STREP. SCREEN	(+)	(-)	N/A
☐ MONOSPOT	(+)	(-)	N/A
☐ URINE DIPSTICK			N/A
☐ INFLUENZA	(+)	(-)	

PROCEDURES

☐ EKG ☐ Pneumococcal
☐ Td ☐ TdaP ☐ Flu
☐ OTHER:_____
☐ HEPATITIS B ☐ HEPATITIS A
☐ TST
☐ STEROID INJECTION: _____
☐ BICILLIN:_____
☐ OTHER _____
☐ HOME BP MONITOR ☐ 24 HR UA
☐ BREATHING TREATMENT
☐ EAR IRRIGATION: RIGHT LEFT BOTH
☐ WOUND CLEANSING: _____
☐ WOUND DRESSING
☐ OTHER: _____

REFERRAL

☐ PHYSICIAN REFERRAL: _____
_____
_____
_____
_____
_____
_____

STUDIES

☐ CHEST X-RAY (2-VIEW) ☐ CT _____
☐ MRI _____ ☐ MMG ☐ CBE
☐ ECHOCARDIOGRAM
☐ VENOUS DOPPLER

NOTES

_____
_____

PATIENT NAME: _____ DOB: _____ SS#: _____ FASTING: YES NO

ORDERING PROVIDER SIGNATURE: _____ NURSE: _____ DATE: _____

DOCUMENT USED IN :
CC EMPLOYEE HEALTH

Collin County Health Services

825 N. McDonald, Suite 130
McKinney, Texas 75069
972-548-5532

Name_____ DOB_____

Review of Test Results from _____

LABORATORY RESULTS

Blood Work:

Complete Blood Count (CBC)	Normal ( ) Abnormal ( )
Complete Metabolic Profile(CMP)	Normal ( ) Abnormal ( )
Thyroid Profile	Normal ( ) Abnormal ( )

Lipid Profile: Fasting / Non-Fasting — Prev.Results from: _____

Total Cholesterol (desired <200)	_____	_____
HDL Cholesterol (desired >40)	_____	_____
LDL Cholesterol (desired <100)	_____	_____
Triglycerides (desired <150)	_____	_____

Liver Function Tests	Normal ( ) Abnormal ( )
Hepatitis Profile	Normal ( ) Abnormal ( )
Hemoglobin AIC (desired <6.5% for diabetics, <6% others)	Normal ( ) Abnormal ( )
Prostate Specific Antigen (PSA)	Normal ( ) Abnormal ( )
C-Reactive Protein (CRP)	Normal ( ) Abnormal ( )
Other: _____	Normal ( ) Abnormal ( )

Urine:

Urinalysis	Normal ( ) Abnormal ( )
Urine Culture	Normal ( ) Abnormal ( )
24 Hr. Urine for Protein (Diabetes)	Normal ( ) Abnormal ( )

Screening Tests:

Stool Occult Blood Test	Normal ( ) Abnormal ( )
Pap Smear	Normal ( ) Abnormal ( )

Other Diagnostic Tests:

Electrocardiogram (EKG)	Normal ( ) Abnormal ( )
Chest X-ray	Normal ( ) Abnormal ( )
Sonogram	Normal ( ) Abnormal ( )
Mammogram	Normal ( ) Abnormal ( )
Other _____	Normal ( ) Abnormal ( )

Comments:_____

_____

_____

_____

_____

_____

Recommendations: ( ) Call to schedule follow up appointment / Follow up with primary care provider
( ) Low fat, high fiber diet
( ) Weight reduction
( ) Stop smoking
( ) Specialist referral needed with _____

Sincerely,

Next Visit: _____

Michael Hale, PA-C/Muriel Marshall, D.O./
Luan Pho, M.D.

Complete Physical Due: _____

Date:_____

DOCUMENT USED IN :
CC EMPLOYEE HEALTH

Collin County Health Services
PROGRESS NOTES

Patient Name:_____ **DOB:**_____

Date	Time	Notes
		BP:_____ P:_____ T:_____ R:_____ O2 Sat:_____% Wt:_____ Ht:_____
		LMP:_____ FSBS:_____ Flow Sheet Reviewed: Yes No
		Wellness Exam within 12 mos. per pt. hx.: Yes No Abn. per pt:
		Immunization status reviewed: Yes No Given today:
		Immunization(s) declined today:
		Screening services (circle encouraged): Colon Eye Exam Wt. Loss Smoking Cess. Diet Diabetic screening: Hb A1c Urine Protein Eye exam Foot exam

DOCUMENT USED IN :
CC EMPLOYEE HEALTH

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

RETURN TO SCHOOL NOTICE

_____ _____
Patient Name Date of Office Visit

To Whom It May Concern:

The above individual was seen at our office on the above referenced date and:

_____ is able to return to school today without restriction.

_____ is able to return to school in _____ days or on _____.

_____ is not to participate in physical education classes/athletics for _____ days.

_____ is not able to return to school pending further evaluation/treatment.

Sincerely,

Michael Hale, PA-C/Muriel Marshall, D.O.
Collin County Employee Health Services

DOCUMENT USED IN :
CC EMPLOYEE HEALTH

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

RETURN TO WORK NOTICE

_____ _____
Patient Name **Date of Birth**

_____ _____
Date of Office Visit **Position**

1. ☐ **Was seen today. Reports being ill since _____.**

2. ☐ **May return to work without restriction(s).**

3. ☐ **May return to work with the following restrictions:**
   - ☐ **May not lift more than _____ pounds,**
   - ☐ **May not sit, stand, or work for greater than _____ minutes at a time without changing position.**
   - ☐ **May not drive or operate machinery**
   - ☐ **Other: _____**

4. ☐ **May return to work on _____ without restriction.**

5. ☐ **May not return to work until further evaluation.**

_____ _____
Michael Hale, PA-C/Muriel Marshall, D.O. **Date**

DOCUMENT USED IN : CC EMPLOYEE HEALTH

Collin County Employee Clinic Questionnaire

Do You Have Or Have You Had Any Of The Following Conditions?

Heart Attack If yes what year?	Yes	No
Heart Failure	Yes	No
Heart Disease	Yes	No
Irregular Heart Rhythm	Yes	No
Rheumatic Fever	Yes	No
High Blood Pressure	Yes	No
Diabetes	Yes	No
Thyroid Disease	Yes	No
Cancer If Yes, what type?	Yes	No
Asthma	Yes	No
Emphysema/Chronic Bronchitis	Yes	No
Tuberculosis	Yes	No
Hearing Loss	Yes	No
Stomach Ulcers	Yes	No
Reflux/Heartburn	Yes	No
Hepatitis/Liver Disease	Yes	No
Intestinal/Colon Disease	Yes	No
Kidney/Bladder Problem	Yes	No
Kidney Stones	Yes	No
Gall Bladder Problem	Yes	No
Hernia	Yes	No
Head or Spinal Injuries	Yes	No
Back/Neck Pain Treated By A Physician	Yes	No
Seizures	Yes	No
Fainting	Yes	No
Loss Of Consciousness	Yes	No
Muscular Disease	Yes	No
Headaches Treated By A Physician	Yes	No
Stroke	Yes	No
Temporary Paralysis	Yes	No
Paralysis	Yes	No
Arthritis Treated By A Physician	Yes	No
Blood/Bleeding Disorder	Yes	No
Radiation Treatment	Yes	No
Treatment for Depression	Yes	No
Treatment for Stress or Anxiety	Yes	No
Ever Attempted Suicide	Yes	No
Syphillis	Yes	No
Gonorrhea	Yes	No
Suffering from any other disease If yes please note the disease:	Yes	No
Extensive Confinement By Illness or Injury	Yes	No
Permanent Defect from Illness Or Injury If Yes, Please note defect:	Yes	No
History of Substance Abuse	Yes	No
Have you ever been hospitalized for treatment?	Yes	No

Have You Had Any Of The Following Surgeries?

Brain/Head	Yes	No	Year	_____
Eye	Yes	No	Year	_____
Ear	Yes	No	Year	_____
Throat/Tonsil	Yes	No	Year	_____
Dental	Yes	No	Year	_____
Thyroid	Yes	No	Year	_____
Lung	Yes	No	Year	_____
Heart	Yes	No	Year	_____
Gall Bladder	Yes	No	Year	_____
Appendix	Yes	No	Year	_____
Hysterectomy	Yes	No	Year	_____
Spine	Yes	No	Year	_____
Other:_____				
Have You Had A Blood Transfusion?	Yes	No	Year	_____
Have You Broken Any Bones?	Yes	No	Year	_____

If Yes, Please note the place on the body where the bone was broken and the outcome:_____
_____
_____

Please List All Medications Taken On A Daily Basis

Name	Dosage	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Do You Have Food Allergies? Yes No
Type: _____
If Yes Please List Reaction:_____
Allergic to Latex? Yes No
If Yes, Please List Reaction:_____

Immunization Status

Tetanus (Td) Booster: Last Date_____
Hepatitis B Series:
Dates _____ _____ _____
1 # 2 # 3

Name:_____ DOB:___/___/_____ Date:_____

DOCUMENT USED IN : CC EMPLOYEE HEALTH

Collin County Employee Clinic Questionnaire

Social Habits

Are You A Tobacco User? Yes No
If yes, smoker or smokeless? Smoker Smokeless
How long have you used tobacco? _____
If former user, when did you quit?_____

Do You Drink Alcohol? Yes No
Have you ever abused alcohol? Yes No NA
Have others expressed concern? Yes No NA

Do You, Or Have You Used Other Drugs? Yes No
If yes, type of substance:_____

Family History

Is There A Family History Of Any Of The Following Conditions In Either Siblings, Parents, Or Grandparents?

Heart Disease Before Age 55 In Males Yes No
Heart Disease Before Age 65 In Females Yes No

High Blood Pressure Yes No

Diabetes Yes No

Cancer Yes No If yes, type? _____

List Any Other Family Medical Conditions Which May Exist
_____
_____

Work History

Have You Had Any Work Injuries or Claims? Yes No
If Yes, Please List Below:

Injury	Date
_____	_____
_____	_____

Have You Ever Received, Or Is There Pending, Or Have You Ever Applied For, Or Intend To Apply For Disability? Yes No
If Yes, Please List Below:
_____
_____
_____
_____

Certification of Information

Do you have any illness or injury you have not reported on the above questionnaire? Yes No
If Yes, Please list:
_____

I certify the above information is complete, true, and correct.

_____ _____
Signature Date

*****DO NOT PROCEED PAST THIS LINE*****

Examiner Notations

_____ _____
Michael Hale, PA-C / Muriel Marshall, DO Date

Name:_____ DOB:___/___/_____ Date:_____

DOCUMENT USED IN : CC EPIDEMIOLOGY

COLLIN COUNTY HEALTH DEPARTMENT

Collin County

ENTERIC DISEASE CASE REPORT

NBS				
	Diagnosis: (Select) **Species type:**	**Date of 1st Symptom** **Lab Date** **Length of Sx:**	**Status: Confirmed**	**NBS#:**

DEMOGRAPHICS

Patient Name: DOB: Age: Years Sex: Female

Ethnicity: Unknown Race: W-White If minor, name of parent/guardian:

Address: City: Zip: Ph: Alt Ph

Physician: Agency: Admit: Discharge: City: Ph:

DAYCARE

Is the child in daycare? **No**
Name of Daycare: Phone:
Name of Director: City:

1. Are any other children ill with same symptoms? -----
   - Number of other children ill: _____
   - Have any been to the doctor? -----
2. Have any of the staff been ill with same symptoms? -----
   - Number of staff ill: _____
   - Have any been to the doctor? -----
   - Were any staff members ill before the patient? -----
3. Was the school aware of this patient's diagnosis?
4. Has the school prepared a letter to go home to all parents in ----- the affected student's class? -----
5. Is a notice posted where all parents can see (ie the front door)? -----
6. Has the daycare contacted its licensing agency? -----

FOOD HANDLER

1. Does the patient work in a restaurant? **No**
   - Name and location of restaurant:
2. Does the patient work in any other setting as a food handler (such as church, caterer, school cafeteria, etc)? -----
   - Name and location of facility: _____
3. Has a local sanitarian been contacted? ----- Date: Sanitarian: _____

PATIENT HISTORY

1. Has patient attended any gatherings where food was served (wedding, picnics, barbeques, potlucks, etc)?No
- Date Location _____
- Has anyone else who was at this event complained of similar symptoms? -----

2. Have any of the patient's close contacts had similar symptoms? No If yes, list information for contact (s) below-

• Name	Age ---	Date of Onset
• Name	Age ---	Date of Onset
• Name	Age ---	Date of Onset
• Name	Age ---	Date of Onset
• Name	Age ---	Date of Onset

3. What and where did you eat 48 hours prior to illness?

Date	Food(s)	Location

4. Has the patient bought produce at any farmer's markets? No Which? What produce? _____
5. Have you had any contact with reptiles (e.g. lizards, snakes, and turtles) No **Type of animal**
6. Have you traveled out of Collin County within the last week (of onset) ? No _____
Comments:

Investigator: Brittany Pollard	Date of Interview:	Person Interviewed:	Phone: 972-548-5596

Revised 3/19/2008

DOCUMENT USED IN : CC EPIDEMIOLOGY

COLLIN COUNTY HEALTH DEPARTMENT

WATER BORNE ILLNESS CASE REPORT

NBS#

DIAGNOSIS: DATE OF ONSET: DURATION: LAB DATE:

Patient Name: DOB: Age: *0* (Select) Sex: (Select)

Ethnicity: (Select) Race: (Select) If minor, name of parent/guardian:

Address: City: Zip: 0 Ph: Alt Ph

Physician: Facility: Admit: Discharge: City: _____ Ph:

DAYCARE

Is the child in daycare? -----
Name of Daycare: _____ Phone:
Name of Director: _____ City: _____
Notes:

1. Are any other children ill with same symptoms? -----
   - Number of other children ill: _____
   - Have any been to the doctor? -----
2. Have any of the staff been ill with same symptoms? -----
   - Number of staff ill: _____
   - Have any been to the doctor? -----
   - Were any staff members ill before the patient? -----
3. Was the school aware of this patient's diagnosis?
4. Has the school prepared a letter to go home to all parents in ----- the affected student's class? -----
5. Is a notice posted where all parents can see (ie the front door)? -----
6. Has the daycare contacted its licensing agency? -----

FOOD HANDLER

1. Does the patient work in a restaurant? -----
   - Name and location of restaurant: _____
2. Does the patient work in any other setting as a food handler (such as church, caterer, school cafeteria, etc)? -----
   - Name and location of facility: _____
3. Has a local sanitarian been contacted? -----

PATIENT HISTORY

1. Have any of the patient's close contacts had similar symptoms? (Select) If yes, list information for contact (s) below-

- Name DOB: Date of Onset
- Name DOB: Date of Onset
- Name DOB: Date of Onset
- Name DOB: Date of Onset

2. Within the two weeks before onset, was the patient in a swimming pool or hot tub? -----
- If yes, where? _____

3. Has the patient been in any outdoor water recreation areas (ie lake, river)? -----
- Where? _____
- Did the patient go swimming? -----

4. Did the patient do hiking and/or camping? -----
- Where? _____
- If yes, did the patient bring in own water or did the patient get water at the hiking/camping site? _____
- Did the patient use a filter to clean water? -----
- Did the patient boil water found at the hiking/camping site? -----

5. Did the patient travel outside of the United States in the two weeks prior to onset of symptoms? -----
- If yes, where?

6. Did the patient participate in any recreational water activities in the two weeks after symptoms resolved? -----
- Where?

Comments:

Investigator: (Select) Date of Interview: Person Interviewed: Phone: (Select)

Revised 1/15/2008

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St Suite 130
McKinney, Texas 75069
www.collincountytx.gov

SCREENING QUESTIONNAIRE FOR ADULT IMMUNIZATION

For patients. The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask our healthcare staff to explain it.

Patient Name: **Date of Birth:**

		Yes	No	Don't Know
1.	Are you sick today?	☐	☐	☐
2.	Do you have allergies to medications, food, or any vaccine?	☐	☐	☐
3.	Have you ever had a serious reaction to a vaccine in the past?	☐	☐	☐
4.	Do you have a long-term health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (e.g. diabetes), or other blood disorder?	☐	☐	☐
5.	Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
6.	Do you take cortisone, prednisone, other steriods, anticancer drugs, drugs that decrease your immune system, or had x-ray treatments?	☐	☐	☐
7.	Have you had a seizure, brain, or other nervous system problem?	☐	☐	☐
8	During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) gobulin in the past year?	☐	☐	☐
9.	For Women: Are you pregnant or is there a chance you could become pregnant during the next month? **First day of last menstrual period:**	☐	☐	☐
10	Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

Did you bring your immunization record card with you today? Yes No

For Women of child bearing age: I understand that if I receive any live virus vaccines during my visit that I should practice birth control of choice for the next four weeks after receiving any live vaccine.

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St Suite 130
McKinney, Texas 75069
www.collincountytx.gov

Questionario Para Adultos

Para Pacientes: Las siguientes preguntas nos ayudaran a determinar cuales vacunas recibiran hoy. "Si" su respuestas son "Si" a cualquiera de estas preguntas no quiere decir que no va a recibir vacunas, quiere decir que le haran preguntas adicionales. Si no entiendes alguna pregunta favor de preguntarle a un empleado.

Nombre del Paciente: apellido / nombre	**Fecha de Nacimiento:** mes / dia / año	Si	No	No Sé
1	Esta enfermo (a) hoy?	☐	☐	☐
2.	Eres alergico a medicinas, comidas ó alguna vacuna?	☐	☐	☐
3.	Has tenido reacciones a vacunas en el pasado?	☐	☐	☐
4.	Has tenido problemas de salud como fatiga, enfermedades de los pulmones, enfermedades del corazón, enfermedades de los riñones, diabetis, or enfermedades en la sangre?	☐	☐	☐
5.	Has tenido cancer, leukemia, sida ó problemas con el sistema inmunológico?	☐	☐	☐
6.	Estas Tomando cortisona, esteroides, drogas para anticancer, drogas para disminuir el sistema inmunologico ó tratamiento de rayos x en los pasados 3 meses?	☐	☐	☐
7.	Has tenido ataques epilecticos o problemas con el sistema nervioso?	☐	☐	☐
8.	Durante el año pasado has recibido tranfusiones de sangre ó productos de sangre ó una medicina llamada inmuno globulina el año pasado?	☐	☐	☐
9.	Para Mujeres solamente: Estas embarazada o cres que vas a quedar embarazada el proximo mes? **Primer dia de el ultimo periodo Menstrual:**	☐	☐	☐
10.	Has recibido vacunas en las pasadas 4 semanas?	☐	☐	☐

Usted trajo la cartilla, record ó registracion de vacunas hoy? Si ó No

Para Mujeres Solamente: Yo entiendo que si recibo una vacuna vivia y debo protegerme para no quedar embarazada 4 semanas despues de recibir vacunas vivas.

Forma completada por: _____ Fecha: _____

Form reviewed by: _____ Date: _____

e information in this consent form is given so that you will be better informed about the health care services you will eive After you are sure you understand the information which will be given about the services and, if you agree to receive services, you must sign this form to indicate that you understand and consent to the services

)TIFICATION:

Collin County Health Care Services
825 N McDonald St. McKinney, TX 75069
Ph: (972) 548-5500 Metro: (972)424-1460 ext.5532

erealter called the Department) encourages individuals to seek a personal physician for periodic health examination and for atment of health problems The Department clinic services are targeted primarily toward prevention of health problems ong those who cannot access a physician. The Department cannot assume the responsibility for payment of medical care ceived outside this clinic, including the delivery of babies, unless previous authorization has been given.

SCLAIMER ON SCREENING: Among its services, the Department utilizes screening tests, which are a method of identifying dividuals who are at risk for developing several common medical problems. In this way they can alert you to promptly seek edical evaluation and treatment from a private physician of your choosing. Screening tests perform a valuable service in lping to find certain diseases early in their course. However, these screening tests do not cover all diseases, and they may iss some cases of diseases they are intended to find. They are not diagnostic and they do not constitute a complete exam.

ENERAL CONSENT: I give permission to the Department, its designated staff and other medical personnel providing ervices under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests, give jections, medications, and other treatments, and render other health services to the patient identified on this form.

NFORMED CONSENT: In addition to the above general consent, I understand that special informed consent forms must be ad and signed for the following procedures: medications for tuberculosis and Hansen's disease, immunization, injectable edication for sexually transmitted diseases, family planning methods, PKU special counseling, HIV testing, and certain ther things.

UESTIONS. I certify that this form has been fully explained to me, that any blank lines have been filled in and that any uestions I have had about the services have been answered to my satisfaction.
have received the HIPPA information today X _____ Patient Int.

IGNATURES Fill in the blank with NA if not applicable.

ECTION 1

alient Name _____ X _____ Patient Signature

erson Authorized to Consent (if not patient) _____ Relationship _____

Signature _____ X _____ Date

Section 2: I will certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested. (This Section is only if you are not allowed to sign for yourself.)

Patient's Name _____ Name of Person Giving Consent _____

Signature of Person Giving Consent _____ Relationship to Patient _____ Date _____

Address _____ City _____ State _____ Zip Code _____

(Hm) Phone Number _____ (Wk) Phone Number _____

Section 3:

Counselor Signature _____ Date _____

Signed copy provided to patient _____
Date Nurse Int

(TDH) L-36 August 1991

DOCUMENT USED IN :
CC IMMUNIZATIONS CLINIC

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

ADULT IMMUNIZATION APPLICATION

Name (as it appears on Social Security Card/Legal Name)

_____ _____ _____ _____
Last Name **First Name** **Middle Name** **Suffix**

Date of Birth: _____ Male ☐ Female ☐ **Social Security Number:**_____
Month / Date / Year

Birth Country:_____ **Mother's Maiden Name:**_____
(Mom's last name before she got married)

Ethnicity:

Alaskan Native American Indian Asian Black / African American Pacific Islander

White / Non-Hispanic White / Hispanic Other_____

Medicaid: Yes No Medicaid Number: _____ Date of Eligibility: _____

Address: _____ _____ _____
Number / Street City Zip Code

Phone Number: _____ Alternate Phone Number: _____

Eligibility Criteria:

I declare that I qualify for vaccines through the Texas Vaccines for Children-Adult Program because (check the first category that applies, check only one):

☐ I do not have health insurance, or

☐ I am underinsured (have health insurance that Does Not pay for vaccines, have a co-pay or deductible that I cannot meet, or have insurance that provides limited wellness or prevention coverage)

☐ I have health insurance that provides wellness or prevention coverage

Insurance Carrier: _____ **Group Number:** _____ **Subscriber ID:** _____

Have you ever had the chicken pox disease, if so what age were you? Yes No _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of the provisions of healthcare services, Collin County creates and maintains health records and other information describing, among other things, my health and medical history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that Collin County reserves the right to charge its Notice and practices with regard to the use and disclosure of health information. I understand that I have the right to request restrictions as to how my health information may be used or disclosed for treatment, payment or healthcare operations, but that Collin County is not required to agree to the requested restrictions.

_____ _____ _____
Name (Print) Signature (Guardian if patient is a minor) Date

DOCUMENT USED IN :
CC IMMUNIZATIONS CLINIC

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

Time:_____
Date:_____

Immunization Application

Information for person receiving immunization:

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State and Health Services. The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

Texas ImmTrac Registry Consent? Yes No

Child's Name (as it appears on Social Security Card/Legal Name)

_____ _____ _____
Child's Last Name **Child's First Name** **Middle Name**

Date of Birth: _____ Male ☐ Female ☐ **Social Security Number:**_____
Month / Day / Year

Birth Country:_____ **Mother's Maiden Name:**_____
(Mom's last name before she got married)

Ethnicity:

Alaskan Native American Indian Asian Black / African American Pacific Islander

White / Non-Hispanic White / Hispanic Other_____

Do You Have Insurance or Are You Underinsured? Insured Underinsured

CHIPS Yes No CHIPS Number: _____ Date of Eligibility: _____

Medicaid: Yes No Medicaid Number: _____ Date of Eligibility: _____

Number of Persons in Household: _____ Household Monthly Income: $_____

Address: _____ _____ _____ _____
Number / Street Apt City Zip Code

Telephone Number: _____ Alternate Phone Number:_____

Responsible Person Name:_____ Relationship:_____

Has your child had the chicken pox disease? Yes No If Yes, When_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of the provisions of healthcare services, Collin County creates and maintains health records and other information describing, among other things, my health and medical history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that Collin County reserves the right to charge its Notice and practices with regard to the use and disclosure of health information. I understand that I have the right to request restrictions as to how my health information may be used or disclosed for treatment, payment or healthcare operations, but that Collin County is not required to agree to the requested restrictions.

_____ _____ _____
Name (Print) Signature (Guardian if patient is a minor) Date

SAMPLE OF PRINTOUT NEEDED IN IMMUNIZATIONS CLINIC FOR PATIENT'S IMMUNIZATION RECORD, EITHER DURING FRONT DESK/REGISTRATION PROCESS, OR CHECK OUT PROCESS

DOCUMENT USED IN : CC IMMUNIZATIONS CLINIC

McKinney-Collin County HD
Thursday, March 11, 2010
Personal Immunization Record

Patient's Name:
Parent/Guardian:
Address:

Birthdate:
IMMTRAC Consent: Yes -
Chart No:
Client ID:

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTaP	02/13/2007	04/13/2007	06/14/2007	12/14/2007		
Hep A Pediatric	03/09/2010					
Hep B - Pedi	12/13/2006	02/13/2007	04/13/2007	06/14/2007		
Hib	02/13/2007	04/13/2007	06/14/2007	12/14/2007		
Inactivated Polio Vaccine	02/13/2007	04/13/2007	06/14/2007			
Measles, Mumps, Rubella	12/14/2007					
Pneumococcal Conjugate	02/13/2007	04/13/2007	06/14/2007	12/14/2007		
Varicella	12/14/2007					

MEDICAL EXEMPTIONS:_____

_____

McKinney-Collin County HD
McKinney-Collin County
825 N. McDonald Street
Suite 130
McKinney, TX 75069
972-548-5532

Certified By _____ Date _____ Phone _____

Older revisions of this form already on file for students in school should not be replaced.

SAMPLE IMM #1--OF PRINTOUT NEEDED FOR IMMUNIZATIONS CLINIC FOR PATIENT WHO IS ALREADY IN IMMTRAC (TOP HALF OF PAGE ONLY; ABOVE LINE)

DOCUMENT USED IN : CC IMMUNIZATIONS CLINIC

Name: JOHN SMITH
Gender: MALE
Address: 111 MAIN ST, ANYTOWN TX 75XXX

Patient ID: XXXXXX (TWICES#)
Birth Date: XX/XX/XXXX
Age: 34 Yrs., 2 Mos., 26 Days

County:

Immunizations To Be Given On Thursday, March 11, 2010 - McKinney-Collin County HD

CPT Code	Vaccine	VIS Date	Lot No.	Mfg.	Site
90636	HepA-HepB	XX/XX/XXXX	XXXXXXX	GSK	Left Arm

Signature / Title of Provider: _____

Screened for Pregnancy? [ ] Yes [ ] No Next shot due on or around _____

1. I agree that the person named above will get the vaccines indicated above.
2. I received or was offered a copy of the Vaccine Information Statement for the vaccine(s) listed above.
3. I know the risks of the diseases this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the diseases, the vaccine, and how the vaccine is given.
6. I know that the person named above will have a vaccine put in his/her body to prevent an infectious disease.
7. I am an adult who can legally consent for the person named above to get vaccines. I freely and voluntarily give my signed permission for this vaccine.

Signature: _____ Date: _____

Client is 18 years or older. Do not fax to ImmTrac.

[**FOR PATIENT WHO DOES NOT HAVE AN IMMTRAC CONSENT ON FILE AND DOES NOT WISH TO PARTICIPATE IN THE PROGRAM, THE STATEMENT SHOWN BELOW WOULD ALSO PRINT ON THIS FORM--]
The ImmTrac Program has been explained to me and I choose NOT to participate in it at this time

_____ _____
Signature Date

SAMPLE IMM #2--OF PRINTOUT NEEDED FOR IMMUNIZATIONS CLINIC FOR PATIENT WHO WOULD LIKE TO PARTICIPATE IN THE IMMTRAC REGISTRY

DOCUMENT USED IN : CC IMMUNIZATIONS CLINIC

Name: JOHN SMITH
Gender: MALE
Address: 111 MAIN ST, ANYTOWN TX, 75XXX

Patient ID: XXXXXX (TWICES ID#)
Birth Date: XX/XX/XXXX
Age: 4 Yrs., 1 Mos., 18 Days

County:

Immunizations To Be Given On Thursday, March 11, 2010 - McKinney-Collin County HD

CPT Code	Vaccine	VIS Date	Lot No.	Mfg.	Site
90696	DTaP/IPV		XXXXXX	GSK	Left Leg
90707	Measles, Mumps, Rubella	03/13/2008	XXXXX	MER	Right Leg
90716	Varicella	03/13/2008	XXXXXX	MER	Left Leg

Signature / Title of Provider: _____

Screened for Pregnancy? [ ] Yes [ ] No Next shot due on or around _____

1. I agree that the person named above will get the vaccines indicated above.
2. I received or was offered a copy of the Vaccine Information Statement for the vaccine(s) listed above.
3. I know the risks of the diseases this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the diseases, the vaccine, and how the vaccine is given.
6. I know that the person named above will have a vaccine put in his/her body to prevent an infectious disease.
7. I am an adult who can legally consent for the person named above to get vaccines. I freely and voluntarily give my signed permission for this vaccine.

Signature: _____ Date: _____

CONSENT FOR THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES IMMUNIZATION REGISTRY

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services. The immunization registry is a secure and confidential service that consolidates and stores your child's immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

I understand that by granting consent below, I register my child in the Texas Department of State Health Service's Immunization registry and authorize the registry to include my child's information in the registry and to release past, present and future immunization records on my child to a parent of the child and any of the following:

- public health district or local health department;
- physician or health care provider;
- insurance company, health maintenance organization or payor;
- school or child care facility in which the child is enrolled and/or
- state agency having legal custody of the child.

I understand that I may withdraw the consent to include information on my child in the ImmTrac Registry and my consent to release information from the registry at any time by written communication to the Texas Department of State Health Services, Immunization Registry, PO Box 149347, Austin, TX 78714-9347.

[ ] I **GRANT** consent for registration. I wish to **INCLUDE** my child's information in the Texas Immunization Registry

_____ _____
Signature of parent, guardian, or managing conservator Date of Signature

ImmTrac Fax:(512)458-7290 Toll free:(866)624-0180

DOCUMENT USED IN :
CC TUBERCULOSIS CLINIC

PHYSICIAN SPUTUM COLLECTION ORDER SHEET
Collin County Health Care Services

Patient _____ DOB _____

3 sputum spec/per week _____

3 sputum spec/per month _____

1 sputum spec/per month _____

No further sputum spec needed _____

Specific dates requested for sputum collection _____

_____

Other _____

DOCUMENT USED IN :
CC TUBERCULOSIS CLINIC

CXR FILM TRACKING

PATIENT NAME_____DOB_____

FILMS REQUESTED FROM WHOM:

CXR x _____ CT x _____

DATE REQUESTED: BY

DATE PICKED UP: BY

TO BE RETURNED NO NEED TO RETURN

FILMS SENT/TAKEN TO:

DATE SENT/TAKEN:

BY:

CCHC NEED TO RETRIEVE CCHC NOT RETRIEVING

WILL BE RETURNED TO CCHC AUTOMATICALLY?

FINAL DISPOSITION:

DOCUMENT USED IN :
CC TUBERCULOSIS CLINIC

COLLIN COUNTY
TB Skin Test

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

Name _____ **Date of Birth** _____ **Department** _____

Please answer the following:

1. Have you ever had a known exposure to a person with an active case of tuberculosis? **Yes** **No**
2. Have you had a positive TB skin test before? **Yes** **No**
   If yes, when? _____ Which facility? _____ Size? _____mm
3. Did you receive treatment for tuberculosis? **Yes** **No**
   What? _____ When? _____
4. Have you been diagnosed with tuberculosis in the past? **Yes** **No**
5. Have you been diagnosed with AIDS, HIV positive, decreased immune system? **Yes** **No**
6. Were you born in the U.S.? **Yes** **No**
   If no, what date did you come to the U.S.? _____
   What country did you come from? _____

In the past year, have you had:

A persistent cough longer than 3 weeks?	**Yes**	**No**	Coughing up blood?	**Yes**	**No**
Unintentional weight loss?	**Yes**	**No**	Profuse night sweats?	**Yes**	**No**
Fatigue?	**Yes**	**No**	Chills?	**Yes**	**No**
Fever?	**Yes**	**No**			

What medicines are you currently taking? (Please list)

_____

Are you taking steroids or receiving any immunosuppressive therapy or chemotherapy? If yes, what type? _____ **Yes** **No**

Have you received any vaccine in the past 6 weeks? _____ If yes, what? _____

When was your last TB skin test?

Date: _____ Result: _____mm Is documentation available? **Yes** **No**

Client Signature: _____ Date: _____

Form CCTB-01

Collin County Health Care Services
Tuberculosis Radiology Referral Form

DOCUMENT USED IN :
CC TUBERCULOSIS CLINIC

Date: _____

Envision Imaging
1111 Raintree Circle, St.100
Allen, Tx 75013
Phone: 972-747-8300
Fax: 972-747-9099

Envision Imaging
3211 Internet Blvd., Ste. 120
Frisco, Tx 75034
Phone: 972-334-0908
Fax: 972-335-0375

Patient Name: _____ D.O.B._____

Address: _____ Male _____ Female_____

Telephone: _____

_____ Alternate Phone#:_____
City State Zip

☐ Case ☐ Contact ☐ Suspect ☐ LTBI ☐ Immigrant ☐ Converter

Mantoux TST Result _____mm Date Administered: _____

On Antituberculosis Medication(s): ☐ Yes ☐ No Infectious: ☐ Yes ☐ No

Service Requested: ☐ Chest x-ray PA

☐ Chest x-ray PA & LAT

☐ CT Scan

_____ _____
Date

Muriel Marshall, DO, Dr PH
Medical Director
Collin County Health Care Services
825 N. McDonald, Ste. 130
McKinney, Texas 75069

********** Please fax report to 972-547-1827**********

Please send bill to: Collin County Health Care Services
Atten: Carmen
825 N. McDonald, Ste. 130
McKinney, Texas 75069

Payment by
Collin County Health Care Services
Is guaranteed ONLY when used at
Envision Imaging.

DOCUMENT USED IN : CC TUBERCULOSIS CLINIC

Instructions for Client

nt's Name _____ Date _____

Physician's Name Muriel Marshall, DO

1. Keep all appointments given to you by clinical staff.
   Several appointments will be necessary to be sure your treatment is working. The treatment for tuberculosis is usually for six or more months. It is very important for you to keep all of the appointments made for you.

   _____
   (client's initials)

2. Be sure you take your medicine for the treatment of your tuberculosis as your doctor or other clinic staff tells you. This means you must: keep all appointments at the clinic or other locations that have been discussed with you; take your medication as advised; provide sputum, urine or blood specimen as requested; report changes in your health; report when you move from where you live now and provide information about those with whom you spend a lot of time. _____
   (client's initials)

3. Come to the Public Health Department Clinic or be at an agreed place and time to take Directly Observed Therapy (DOT). DOT is a way we can be sure that you take all the medication needed to cure your tuberculosis. Taking DOT means that a health care worker will meet you at a scheduled time and place and give you your medication as ordered by the doctor. Location for DOT _____ / _____. DOT will give you the best chance to cure your TB. _____
   (location) (client's initials)
   (client's initials)

4. Do not return to work or school until authorized by your clinic physician. _____
   (client's initials)

5. Do not allow anyone other than those living with you or health department staff into your home until authorized.

   _____
   (client's initials)

6. Do not leave your home unless authorized by your clinic physician. _____
   (client's initials)

   You are or may be capable of spreading TB to others and must remain in your home or in a place where you will not expose others to the TB germ. When you take your TB medicines, you may quickly decrease the likelihood of spreading TB to others. Your doctor will decide when this occurs at your follow-up appointments.

   _____ / _____
   (client's initials) (physician's signature) (date)

   You may attend school and/or go to work _____ / _____
   (client's initials) (physician's signature) (date)

7. Special orders. (1) Do not get on an airplane, bus, train or any public transportation until authorized by the TB clinic Physician. (2) If you develop shortness of breath, chest pain, difficulty breathing, or any urgent medical condition: call 911 or go e nearest ER. Wear your mask and notify ER staff that you are taking TB meds.

   _____
   (client's initials)

DOCUMENT USED IN :
CC TUBERCULOSIS CLINIC

PHYSICIAN SPUTUM COLLECTION ORDER SHEET
Collin County Health Care Services

Patient _____ DOB _____

3 sputum spec/per week _____

3 sputum spec/per month _____

1 sputum spec/per month _____

No further sputum spec needed _____

Specific dates requested for sputum collection _____

_____

Other _____

DOCUMENT USED IN :
CC TUBERCULOSIS CLINIC

TB CLINIC
Collin County Health Care Services
Non TB Meds

Patient: DOB:

Medication, Name & Strength / Dosing Instructions	Start Date / Stop Date	Diagnosis / Provider	Date / Change	Date / Change	Date / Change	Date / Change	Reason for Discontinue

☐ Continued on Next Sheet ☐ Continued from Previous Sheet

TB Clinic Non TB Meds 5/2/08

DOCUMENT USED IN : CC TUBERCULOSIS CLINIC

Physician Office Visit—PST Evaluation
Collin County TB Clinic

Date: _____

Patient Name: _____ _____ yr old Male Female

Born @ _____ Came to the U.S. _____ from _____

Referred By _____ on Date: _____ Translator: No Yes _____ name

S:

1. Have you had any:

Fever?	Yes	No				
Cough?	Yes	No	Productive?	Yes	No	Color? _____
			Nonproductive?	Yes	No	How long? _____
Chills?	Yes	No				
Night sweats?	Yes	No				
Weight loss?	Yes	No	____ lbs during last ____ wks ____ mo.			
Decreased appetite?	Yes	No				
Coughing up blood?	Yes	No	_____			

2. Current meds: _____
   Use of meds for:
   Psoriasis, arthritis OR Crohn's Disease? _____ infliximab (Remicade) _____
   golimumab (Simponi) _____ adalimunab (Humira) _____
   etanercept (Enbrel) _____ certdizumab (Cimzia) _____

3. Current occupation: _____

4. Alcohol? Former Yes No How much? _____ How often? _____

5. Tobacco use? Former Yes No Began at age? _____ How much? _____

6. Drug use? Former Yes No _____

7. History of:

Hepatitis A, B, or C	Yes	No
Liver disease	Yes	No
Diabetes	Yes	No
HIV/AIDS	Yes	No
Immunosuppression	Yes	No
Cancer	Yes	No
Lung disease	Yes	No

   Other _____

8. FDLMP _____

9. Travel outside of the U.S.? (dates, duration) _____

10. Any known exposure to TB? Yes No Family history of TB: _____
    (When/Where?) _____

11. Have you ever taken INH before? _____ Any TB meds? _____

DOCUMENT USED IN : CC TUBERCULOSIS CLINIC

O: 1. Positive TST _____mm on _____ Denied previous TST _____
Previous TST: Positive _____ Negative _____ Date: _____

. Chest x-ray report of _____ Negative _____

. PE: Alert, cooperative NAD, Ox3 Wt: _____ BP: _____ HR _____ Temp_____

Jaundice	Yes	No	HRRR
Icterus (Scleral)	Yes	No	Lungs:
Hepatosplenomgaly	Yes	No	No rash noted
Ant./Post. cervical lymphadenopathy	Yes	No	No cough/cough _____during exam

4. Asymptomatic Symptomatic: Suspect LTBI (low suspicion of active disease)
1) Collect sputums x3
2) HIV, CMP ____ local ____ state, CBC _____
3) RTC when above completed

A: LTBI

P: 1) Benefits and risks of INH discussed

2) Client desires to start INH

_____ Draw LFT's - Local State

_____ Draw HIV, Hepatitis Screen

_____ INH - 300 mg po daily x 9 mo.

_____ B6 - _____ mg po daily x 9 mo.

_____ Work/school note given

_____ RTC monthly

_____ Patient advised if any nausea, vomiting, yellowing of skin or eyes, abdominal pain, change in color of urine or stool, fatigue, call TB clinic immediately at 972-548-5510.

_____ Patient advised no alcohol, no Tylenol/acetaminophen, no pregnancy

_____ Please give patient pregnancy form

_____ Draw Monthly Labs - Local State

_____ Obtain name/contact info of all physicians & obtain written consents

_____ Advised patient to follow up with PMD/PCP for non-TB health issues

2) Client refuses INH

Advised patient if develop any fever, cough, chills, night sweats, weight loss, or coughing up blood seek medical attention immediately and notify the health department. _____

Work/school note given _____

Advised if desires to start INH, return for re-evaluation. _____

Give Declination form _____

_____
Muriel Marshall, DO, DrPH

_____
Luan Pho, M.D.

TBPV TST Evaluation Form Revised 10/5/09

Physician Office Visit—Immigration Evaluation
Collin County TB Clinic

DOCUMENT USED IN : CC TUBERCULOSIS CLINIC

Date: _____

Patient Name: _____ _____ yr old Male Female

Born @ _____ Came to the U.S. _____ from _____

Referred By _____ on Date: _____ Translator: No , Yes _____ name

S:

1. Have you had any:

Fever?	Yes	No				
Cough?	Yes	No	Productive?	Yes	No	Color? _____
			Nonproductive?	Yes	No	How long? _____
Chills?	Yes	No				
Night sweats?	Yes	No				
Weight loss?	Yes	No	____ lbs during last ____ wks ____ mo.			
Decreased appetite?	Yes	No				
Coughing up blood?	Yes	No	_____			

2. Current meds: _____
   Use of meds for:
   Psoriasis, arthritis OR Crohn's Disease ? _____ infliximab (Remicade) _____
   golimumab (Simponi) _____ adalimunab (Humira) _____
   etanercept (Enbrel) _____ certdizumab (Cimzia) _____

3. Occupation: _____

4. Alcohol? Former Yes No How much? _____ How often? _____

5. Tobacco use? Former Yes No Began at age? _____ How much? _____

6. Drug use? Former Yes No _____

7. History of:

Hepatitis A, B, or C	Yes	No
Liver disease	Yes	No
Diabetes	Yes	No
HIV/AIDS	Yes	No
Immunosuppression	Yes	No
Cancer	Yes	No
Lung disease	Yes	No
Other	_____	

8. FDLMP _____

9. Travel outside of the U.S.? (dates, duration) _____

10. Any known exposure to TB? Yes No Family history of TB: _____
    (When/Where?) _____

11. Have you ever taken INH before? _____ Any TB meds? _____

12. BCG Vaccine? Yes No Uncertain

DOCUMENT USED IN : CC TUBERCULOSIS CLINIC

O:

1. Positive TST _____mm on _____ Denied previous TST _____
   Previous TST: Positive _____ Negative _____ Date: _____
   Quantiferon Gold: Positive _____ Negative _____ Indeterminate _____ Date: _____

2. Chest x-ray report of _____ Negative _____

3. PE: Alert, cooperative NAD, Ox3 Wt: _____ BP: _____ HR _____ Temp_____

Jaundice	Yes	No	HRRR
Icterus (Scleral)	Yes	No	Lungs:
Hepatosplenomgaly	Yes	No	No rash noted
Ant./Post. cervical lymphadenopathy	Yes	No	No cough/cough _____during exam

A: Immigration Evaluation, B_1, B_2, B_3 _____ other
Asymptomatic/Symptomatic
Lo/High Suspicion of active Disease

P:

_____ Collect Sputums X3 (Induce)

_____ HIV, CMP, CBC today, Hepatitis Screen

_____ CXR (2v) with comparison

_____ RTC when the above completed

_____ Advised patient if develop any fever, cough, chills, night sweats, weight loss, or coughing up blood seek medical attention immediately and notify the health department—TB Clinic.

_____ Advised patient to follow up with PMD/PCP for non-TB health issues

_____ Obtain name/contact info of all physicians & obtain written consents

_____ Other:

_____
Muriel Marshall, DO, DrPH

_____
Luan Pho, M.D.

TBPV Immigration Evaluation Form Revised 10/5/09

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

DOCUMENT USED IN :
CC TUBERCULOSIS CLINIC

Date: _____

Patient Name: _____

Date of Birth: _____

Has a documented Positive PPD skin test with a measurement of _____ mm on _____.

Chest x-ray done on _____ does not show active disease.

- No more TB skin tests in the future.
- Follow-up with annual symptom review.
- Is not considered to be contagious for Tuberculosis.
- May return to work/school.

_____
Muriel Marshall, DO, DrPH
Collin County Health Authority

DOCUMENT USED IN :
CC TUBERCULOSIS CLINIC

CLIENT NAME: _____
DATE OF BIRTH: _____

TB CLINIC
PHYSICIAN ORDER SHEET

DATE		NOTED

DOCUMENT USED IN :
CC TUBERCULOSIS CLINIC

Health Record

Progress Notes

Client Name________________________

____

Date of Birth______________________

Date	

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

DOCUMENT USED IN :
CC TUBERCULOSIS CLINIC

Date: _____

I, _____, have been advised by Dr. _____ and I understand that I should take precautions to prevent pregnancy while taking Tuberculosis (TB) medication because of the deleterious effects this medication could have on the unborn child. If I do become pregnant, I will notify the TB Clinic immediately at (972) 548-5510. I understand that TB medications, Rifampin and Rifabutin, can cause my birth control pills not to work properly.

I understand that I need to call the TB clinic immediately if I miss my period.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

DOCUMENT USED IN :
CC TUBERCULOSIS CLINIC

PATIENT CONTACT INFORMATION

Family Member: _____ Relationship: _____
Phone #'s: _____

Family Member: _____ Relationship: _____
Phone #'s: _____

Family Member: _____ Relationship: _____
Phone #'s: _____

OTHER PROVIDERS:

Name: _____ Specialty: _____
Office #: _____ Fax #: _____
Address: _____

Name: _____ Specialty: _____
Office #: _____ Fax #: _____
Address: _____

Name: _____ Specialty: _____
Office #: _____ Fax #: _____
Address: _____

Name: _____ Specialty: _____
Office #: _____ Fax #: _____
Address: _____

Name: _____ Specialty: _____
Office #: _____ Fax #: _____
Address: _____

DOCUMENT USED IN :
CC STD CLINIC

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

Note: Information obtained in this clinic is strictly confidential.

Patient Registration Form

Date: _____

Name: _____ Date of Birth. _____

Address: _____
(Number) (Street) (Apt.)

Sex: Male Female Social Sec. #. _____

_____
(City) (State) (County) (Zip)

Marital Status. Single Married Separated Divorced Widowed

Phone: _____ _____
(Home) (Work)

Ethnicity: Hispanic Non-Hispanic

Work/School _____
(Place)

Race White Black Am. Indian Asian/Pacific Isl. Other/Unknown

Address: _____
(Number) (Street) (City)

Preferred Language: _____

In case of emergency, please contact:

_____ _____
(Name) (Address)

_____ _____
(Phone) (Relationship)

By completion of this form, I hereby give permission for the Collin County Health Care Services clinic staff to perform diagnostic tests including HIV and to render definitive or prophylactic treatment as deemed necessary.

_____ _____
Patient Signature Date

_____ _____
Witness Date

Revised 1/29/07 – Adopted from
Dallas County Health & Human Services
STD Clinic

COLLIN COUNTY
McKinney, Texas 75069
www.collincountytx.gov

DOCUMENT USED IN :
CC STD CLINIC

Nota: La información obtenida en esta clínica es terminantemente confidencial.

Forma de registro paciente

Fecha _____

Nombre: _____ Fecha de nacimiento _____

Dirección: _____ Sexo: Varón HembraSec social. #: _____
(Número) (Calle) (Conveniente.)

_____ Estado civil: Solo Casado Separado
(Ciudad) (Estado) (Condado) (Cierre relámpago) Divorciado Widowed

Teléfono _____ _____ Pertenencia étnica. Hispanico No-Hispanico
(Hogar) (Trabajo)

Trabajo/escuela: ___ _____ Raza: Blanco Negro Am. Indio
(Lugar) Isl asiático/ pacifico. Otro/desconocido

Dirección: _____ Lengua preferida: _____
(Número) (Calle) (Ciudad)

En caso de urgencia, entre en contacto con por favor:

_____ _____
(Nombre) (Dirección)

_____ _____
(Teléfono) (Relación)

Por la terminación de esta forma, doy por este medio el permiso para que el personal de la clinica de los servicios del cuidado médico del condado de Collin realice pruebas de diagnóstico incluyendo el VIH y rinda el tratamiento definitivo o profiláctico según lo juzgado necesario.

_____ _____
(Nombre) (Fecha)

_____ _____
(Testigo) (Fecha)

1/29/07 revisado - Adoptado de
Dallas Condado Salud y servicios humanos
Clinica del STD

Collin County Health Care Services
Medical History and Risk Assessment

Date: _____

Name: _____

Age: _____

Reason for Visit: _____

History Form

This form will aid in taking your medical history and be part of your permanent record. Please answer YES or NO to the following questions. If you do not understand a question, leave it blank.

Family History: Has anyone in your family had trouble with the following? Include Mother (M), Father (F), Brother (B), Sister (S), Grandmother (GM), Grandfather (GF).

	No	Yes	Who		No	Yes	Who		No	Yes	Who
Stroke				Liver Disease				Thyroid Disease			
High Blood Pressure				Lung Disease				Diabetes			
Heart Problems				Tuberculosis				Cancer			
Congenital Abnorm.				Epilepsy				Multi. Pregnancy			

Medical History: Have you had any of the following:

No	Yes		No	Yes		No	Yes	
		Anemia			Congenital Anomaly			Liver Disease
		Contact Lens			High Blood Pressure			Kidney Infection
		Rubella			Heart Problems			Pelvic Tumor/Fibroids
		Severe Headaches			Rheumatic Fever			Tumor of Ovary
		Stroke			Asthma			Pelvic Infection
		Seizures			Lung Disease			Venereal Disease Kind: _____
		Severe Depression			Blood Clots			Vaginal Bleeding
		Diabetes			Varicose Veins			Vaginal Discharge
		Cancer			Stomach/Bowel Problem			Abnormal PAP Smear
		Thyroid Problem			Blood Transfusion			Are you healthy?
		Breast Lump/Discharge			Allergies (list)			Do you smoke? Amt. _____
								Do you drink? Amt. _____
								Use illicit drugs? Type: _____

Please list all **medications** you are taking now.

_____

_____

_____

Operations/Hospitalization: Type, Date, Physician

_____

_____

_____

Menstrual History	**Contraceptive History**	**Pregnancy History (#)**
_____ Age Period Started	Do you use birth control method now? _____	_____ Pregnancies (total)
Periods are: _____ Regular _____ Light	Is yes, what? (list name, dose, type)	_____ Premature Births
_____ Irregular _____ Moderate	_____	_____ Abortions
_____ Painful _____ Heavy	Methods used in the past?	_____ Miscarriages
Periods come every _____ days	_____	_____ Stillbirths
First day of last period _____	Comments: (Problems w/methods)	_____ Live Births
Pain during intercourse _____	_____	_____ Ectopic (Tubal) Pregnancies
Bleeding during intercourse _____	Number of partners: _____	_____ Cesarean
If periods have stopped, give year of last period. _____	Sexual Orientation: _____	_____ Living Children
	Sexual Abuse? _____	Complications / Comments:
Date of last pap smear _____		_____
Normal / Abnormal (circle)	**Breast History:**	_____
RX _____	Breast self exam Yes No	
_____	Breast Implants? Yes No	_____
_____	Last Mammogram Date _____ N/A	_____
	History of Breast Bx. or Cancer Yes No	Date/procedure

DOCUMENT USED IN :
CC WELL WOMAN

COLLIN COUNTY

Human Resources
210 S. McDonald Street Suite 612
McKinney, Texas 75069
Phone: (972) 548-4606
Fax: (972) 547-5735

Annual Physical Reimbursement Request

Section to be completed by Collin County employee (please print)

Patient's Name: _____

Insured's Name: _____

Insured's Social Security #: _____

Date of Exam: _____

Relationship to Insured:

☐ Self ☐ Spouse

Section to be completed by physician

The above patient has undergone the recommended age specific, gender specific annual risk assessment and physical examination.

This exam included (Please check all that apply):

☐ Annual Comprehensive Physical Examination: This exam was not associated with the treatment of an ailment and depending on age and medical history may have covered a number of factors such as weight, cholesterol levels, blood pressure, diabetes screening, and various cancer screenings.

☐ Well Woman Examination: This exam was not associated with the treatment of an ailment and included recommended age specific, gender specific tests such as annual breast exams, mammogram and cervical cancer screening.

☐ Well Man Examination: This exam was not associated with the treatment of an ailment and may have included an annual prostate exam.

_____ Signature of Healthcare Provider

_____ Date

_____ Please affix Healthcare Provider/Office stamp here

DOCUMENT USED IN :
CC WELL WOMAN

COLLIN COUNTY HEALTH DEPT.

DATE: _____ NAME: _____

AGE: _____

OB HISTORY: Gravida _____ Para _____ Ab _____ Living Children _____

LMP: _____ Duration _____ Flow _____ Frequency _____

CONTRACEPTION: _____

LAST PAP SMEAR: Date _____

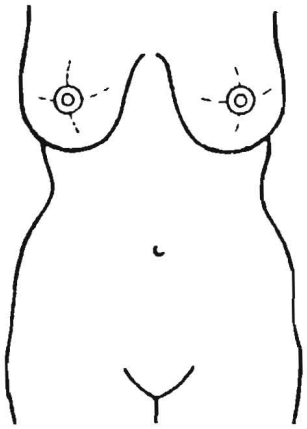
MEDICAL HISTORY: Allergies _____

Medications _____

Surgeries _____

Mammo _____

Smoker (Y) (N)



CHIEF COMPLAINT: _____

_____

_____

_____ U/A _____

EXAM: BP _____ Weight _____ Prev Wt _____ Height _____ HCT _____

General: WDWN thin obese Stool _____

EENT: NECK: THYROID: normal Chol _____

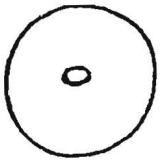
BREASTS: right - normal left - normal BS _____

CHEST: clear

HEART: normal

EXTREMITIES: normal

ABDOMEN: normal scar



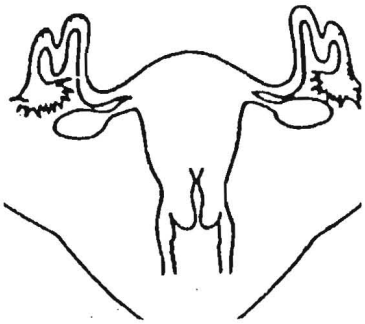
PELVIS:

EXT. GEN'L: normal atrophic

OUTLET: normal cysto recto asymp

VAGINA: normal atrophic

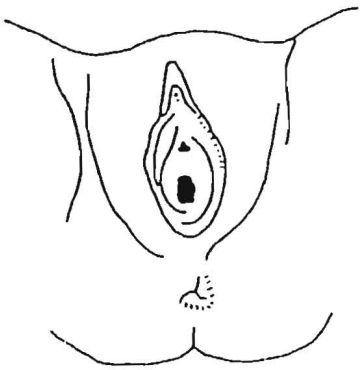
CERVIX: normal



UTERUS: Size -normal

Shape -normal

Position -mid AV RV



ADNEXA: Right -normal

Left -normal

RECTOVAG: Confirms

PAP - Yes, No

Wet Prep _____

Instructed on BSE ( )

Mammogram: to schedule ( ) up to date ( )

Discussed B.C.: happy with hers ( ) discussed options ( )

Discussed risks/benefits of HRT ( )

IMP: _____ PLAN: _____

_____ _____

_____ _____

_____ _____

Collin County Flow Sheet

CLIENT NAME----------

DATE OF BIRTH----------

Date	B/P	Wt.	Pap smear results	Reason for visit

DOCUMENT USED IN :
CC WELL WOMAN

Collin County Health Services
Well Woman Exam

825 N. McDonald St. #130
McKinney, TX. 75069
972-548-5502

Name _____ DOB: _____ Date _____

Review of Test Results from _____

LABORATORY RESULTS

Blood Work:

Complete Blood Count (CBC)	Normal ( ) Abnormal ( )
Complete Metabolic Profile (CMP)	Normal ( ) Abnormal ( )
Thyroid Profile	Normal ( ) Abnormal ( )

Lipid Profile: Prev. Results from _____

Total Cholesterol (desired <200)	_____	_____
HDL Cholesterol (desired >40)	_____	_____
LDL Cholesterol (desired <100)	_____	_____
Triglycerides (desired <150)	_____	_____

Liver Function Tests	Normal ( ) Abnormal ( )
Hepatitis Profile	Normal ( ) Abnormal ( )
Hemoglobin AIC (desired <7.0)	Normal ( ) Abnormal ( )

Urine:

Urinalysis	Normal ( ) Abnormal ( )
Urine Culture	Normal ( ) Abnormal ( )
24 Hr. Urine for Protein (Diabetes)	Normal ( ) Abnormal ( )

Screening Tests:

Pap Smear	Normal ( ) Abnormal ( )
HPV Test	Normal ( ) Abnormal ( )
Stool Occult Blood	Normal ( ) Abnormal ( )

Other Diagnostic Tests:

Mammogram	Normal ( ) Abnormal ( )
Other: _____	Normal ( ) Abnormal ( )

Comments: _____

Recommendations: ( ) Call to schedule follow up appointment
( ) Low fat, high fiber diet
( ) Weight reduction
( ) Stop smoking
( ) Specialist referral needed with _____

Sincerely,

Follow Up Visit: _____

Belsy Koruthu, WHNP Dr. Muriel Marshall, D.O. Dr. Luan Pho, M.D.

REFERRAL FORM

Referral Date: _____ Appt. Date: _____

TO: Name and Address of Receiving Agency or Person

FROM: Collin County Health Care Services
825 N. McDonald Street
McKinney, Texas 75069
Phone: 972-548-5500 Metro: 972-424-1460
Fax #: 972-548-5550

Client's Name _____ Social Security Number _____

Address _____ Birthday _____ Sex (M) (F)

City _____ State _____ Zip Code _____ (_____)_____ Telephone (Home) or (Work)

Belsy Koruthu, WHNP _____
Signature & Title
Muriel Marshall, D.O. MPH.

RETURN RESPONSE REQUESTED

Signature signifies receipt/knowledge of this referral and authorizes the referring agency to release information necessary for its completion and the referring agency is released from all legal responsibility that may arise from this act.

_____
Signature of Client/Parent/Guardian

FINDINGS AND SERVICE RENDERED:

Collin County Health Care
Progress Notes

Client Name: _____
(Last, First)

Date of Birth: _____
(MM/DD/YY)

Date	Time	Notes

DOCUMENT USED IN :
CC KOMEN CLINIC

COLLIN COUNTY

Health Care Services

KOMEN GRANT SERVICES

Welcome to Collin County Komen clinic. Due to a grant from the Komen Foundation we are able to provide.

1. A clinical breast exam
2. Mammogram
3. Breast education

If an abnormality is noted on breast exam and/or mammogram, you are responsible for your follow-up and treatment You will be referred to your Primary Care doctor for referral to a breast surgeon. You may also select a breast surgeon of your choice. Collin County does not schedule or cover the costs of any diagnostic tests (such as biopsies, CT, MRI, etc) or treatment.

If any abnormalities are noted, you will also be given the contact information for the Bridge Breast Center. You will need to call them. They have specific qualification requirements. They will determine if you qualify for any recommended biopsies and treatment with their program. Bridge Breast Center: 214-821-3820.

I, _____ have been informed that Collin County Komen clinic will provide a physical exam of the breast, mammogram and breast education but that I am responsible for scheduling and paying for any further diagnostic evaluations (such as biopsies) and treatment that is necessary and recommended; including but not limited to, breast infections, nipple discharge, breast pain in the absence of a mass, breast masses/breast lumps, breast rashes or any condition of the breast. I hold harmless and release Collin County, Collin County Health Care Services, Belsy Koruthu, WHNP and Muriel Marshall, D.O. of any liability for any adverse events, mental duress, or adverse outcomes in health including but not limited to breast cancer or spread of breast cancer. I realize that it is very important for my health and can result in serious adverse outcomes, including death, if I do not call Bridge Breast Center or the breast surgeon of my choice immediately if I am informed of an abnormality so that timely diagnosis and treatment can begin with the provider of my choice. I understand that Collin County does not offer treatment or necessary further diagnostic tests.

_____ _____
Signature Date

_____ _____
Witness Printed Name & Signature Date

825 N. McDonald St. • McKinney, Texas 75069 • (972) 548-5500 • Fax (972) 548-5550
Metro (972) 424-1460 Ext. 5500

DOCUMENT USED IN :
CC KOMEN CLINIC

COLLIN COUNTY

Collin County Health Care
825 N. McDonald Street
Suite 130
McKinney, Texas 75069
www.collincountytx.gov

Appt. Date: _____

Appt. Time: _____

Presbyterian of Allen Breast Center
1105 Central Expwy. Building 2 Ste. 2100
Allen, TX. 75013
Located on the 1st floor.
972-747-6000

DIRECTIONS:

Plano/Murphy/Nevada/Richardson/Dallas Areas:

1. North on Hwy 75
2. Go past the Bethany and McDermott exit.
3. Exit Exchange Pkwy

McKinney/Anna/Melissa Areas:

1. South on Hwy 75
2. Go past the Stacy Rd. Exit
3. Exit Exchange Pkwy

Frisco Area:

1. East on Hwy 121, go to McKinney
2. Get on Hwy 75 South
3. Go past the Stacy Rd. exit
4. Exit Exchange Pkwy

Princeton/Farmersville/Wylie/Sachse Areas:

1. From Hwy 78 North
2. West on Hwy 380 (University)
3. Go to Hwy 75 South
4. Go past the Stacy Rd. Exit
5. Exit Exchange Pkwy

If you are starting from Health Care Services

1. Go South on Hwy 5 (McDonald St.)
2. Get on Hwy 75 going South
3. Go past Stacy Rd. Exit
4. Exit Exchange Pkwy

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

Facsimile Transmittal

To: **From:** Belsy Koruthu, WHNP

Fax: **Pages:**

Phone: **Date:**

Re: **CC:**

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

- **Comments:**

Belsy Koruthu, RNC,WHNP-BC

Collin County Health care Services

825 N.McDonald St., McKinney., Tx 75069.

Phone # 972 548 5529

Fax # 972 548 5550

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DOCUMENT USED IN : CC KOMEN CLINIC

12108-10

HEALTH RECORD – PROGRESS NOTES

☐ Initial ☐ Re-Exam ☐ Annual-return

Client Name: _____
Date of Birth: _____

Date	Time	Notes
		S: ____ female / male presents for breast exam. ☐ Denies any breast problems ☐ States: _____ _____ ☐ Denies any breast biopsies ☐ Breast biopsy (date) _____ (result) _____ ☐ Denies breast implants ☐ Monthly BSE ☐ Yes ☐ No ☐ Smoke ☐ Yes ☐ No _____ ☐ Caffeine ☐ Yes ☐ No _____ ☐ Denies any family history of breast cancer ☐ Family history: _____ diagnosed at age ____ living, died @ age _____ from _____ _____ diagnosed at age ____ living, died @ age _____ from _____ _____ diagnosed at age ____ living, died @ age _____ from _____ ☐ Current medications:_____ ☐ Denies hormones, BCP Gr ___ P ___ Living children ___ Miscarriage/Ab ___ Breastfed ( ) Yes ( ) No ☐ Last MMG: _____ @ _____ Per pt was ☐ NORMAL ☐ ABNORMAL ☐ Denies ever having MMG ☐ FDLMP: _____ **O:** CBE: ☐ No masses ☐ No tenderness or pain on palpation ☐ No nipple discharge ☐ No skin changes ☐ No nipple inversion ☐ No supraclavicular, infraclavicular or axillary lymphadenopathy _____ **A:** ☐ CBE completed ☐ Noted:_____ **P:** ☐ Schedule bilateral screening MMG ☐ Schedule bilateral diagnostic MMG _____ ☐ Schedule sonogram ☐ left ☐ right ☐ bilateral ☐ Advised pt of importance of monthly self breast exams and how to do BSE ☐ Advised pt to report immediately for re-evaluation if any breast lumps, problems, questions or concerns ☐ Advised pt on importance of annual MMG, sooner if needed ☐ Advised pt to collect copy of previous MMG films and take to pending MMG appt. ☐ RTC dependant on pending MMG ☐ Educational material given: ☐ Literature ☐ Hands On Practice on Model ☐ Referral faxed to PABC ( ) Yes ( ) No date/time: _____ ☐ Scheduled appt. with PABC ( ) Yes ( ) No date/time: _____ ☐ Pt. informed of date/time of appt. ( ) Yes ( ) No ☐ Pt. verbalized understanding ( ) Yes ( ) No

Luan Pho, M.D. Muriel Marshall, DO Belsy Koruthu, WHNP

CCHCS Health Record Progress Notes 10/06/06

DOCUMENT USED IN :
CC KOMEN CLINIC

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

Date: _____/_____/_____

Dear _____,

The following information marked pertains to you.

NORMAL:

_____ The mammogram you recently had at PABC through Collin County Health Care Services is NORMAL.

_____ The American Cancer Society recommends yearly clinical breast exams and mammograms.

_____ You need a follow up appointment by _____ about _____.

_____ Self breast exams need to be done monthly. If you have any problems call **972-548-5529** or return to the clinic for a follow up appointment.

_____ If you have no problems the next clinical breast exam/mammogram is due on or after _____.

ABNORMAL:

_____ We have been trying to contact you by phone but have been unable to do so.

_____ You need further evaluation here at Collin County Health Care Services on _____. Please call **972-548-5524 or 972-548-5529** for an appointment.

_____ You need further evaluation at _____.
Please call: _____.

Thank you,

Belsy Koruthu RNC, WHNP
Collin County Health Department
STD Clinic

DOCUMENT USED IN :
CC KOMEN CLINIC

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

Date

Dear Mr./Ms. ,

You have missed your follow up appointment on _____/____/_____ at _____.
We have attempted to reach you via (☐ letter ☐ telephone) without any response (☐ no answer ☐ phone number changed ☐ left message to call us back). It is important that you contact our office regarding:

☐ Evaluation/Follow up treatment through Bridge Breast Center

☐ Returning to Texas Health—Presbyterian Hospital of Allen for additional x-rays

☐ Texas Health Presbyterian Breast Center needs previous films for comparison—
Please call 972-747-6000 to make arrangements

☐ _____

It is your responsibility to keep your no cost appointments or call to cancel/reschedule your appointment. If you do not follow up, it may seriously impact your health, including, but not limited to, breast cancer, the spread of cancer, or other deadly complications.

Please respond by checking the box(es) shown below and mail this letter back to us in the envelope provided. If we do not hear from you in 30 days, your case will be closed.

☐ I would appreciate a return call. The best day and time call me is _____at ___ (am/pm).
The phone number I can best be reached at is (___) ____ - _____.

☐ I have made the follow up appointment with Collin County Health Care Services (CCHCS) on
___/____/____ at ___:_____ (a.m. / p.m)

☐ I prefer to follow up with Dr. _____ at my own expense.

☐ I decline further evaluation/treatment by CCHCS.

☐ _____

Thank you in advance for your cooperation and assistance.

Sincerely yours,

Belsy Koruthu, WHNP-C
Nurse Practioner
Collin County Health Care Services
825 N. McDonald Street
McKinney, Texas 75069
972-548-5529

BK:jlg

CONFIDENTIAL DISCLAIMER
In accordance with the HIPAA (Health Insurance Portability and Accountability Act), this letter contains protected health information and is for the sole use of the intended recipient(s). Any unauthorized use, disclosure, dissemination, or copying of this information is prohibited. If you receive this in error, please notify the sender immediately and destroy the information.

DOCUMENT USED IN : CC STD CLINIC

43670

SYPHILIS SEROLOGY
Form No:SER

☐ CORRECTED REPORT

TESTING LAB:
☐ Dallas Co.Hlth/Hum.Svcs.Laboratory CLIA#45D0672012
☐ Dallas Co.Hlth/Hum.Svcs.MOBILE CLIA#45D0994679

LAB #: DATE CHECKED IN: DATE REPORTED:

DO NOT MARK ABOVE THIS LINE. PRINT BELOW WITH BALLPOINT OR TYPEWRITER. ASTERISKED(*)INFORMATION MUST BE PROVIDED BY SUBMITTER. PLEASE FILL IN THE DATA USING THE UPPERCASE CHARACTERS.

PATIENT LABEL:

PLACE THE LABEL INSIDE THIS BOX

FUNDING: ☐ Title V ☐ Title X ☐ Title XX ☐ Medicaid

(*) SEX: ☐ MALE ☐ FEMALE

(*) ETHNICITY: ☐ Hisp ☐ NonHisp

(*) RACE: ☐ A ☐ AI ☐ B ☐ MR ☐ W

(*) DATE COLLECTED: __ / __ / ____

(*) FP SITE: ☐ BF ☐ DH ☐ ED ☐ GAR ☐ GP ☐ LJ ☐ MP ☐ OW ☐ VIC ☐ Other _____

(*) LAST NAME

(*) FIRST NAME M.I. (*) BIRTH DATE __ / __ / ____

STREET

APT NO CITY STATE ZIP CODE

SSN ___ - __ - ____ PHONE# (___) - ___ - ____
Area Code

(*) Send Report to:
☐ COL CO ☐ CD ☐ EH ☐ MV ☐ NT-HRC ☐ REF ☐ T&C ☐ TB ☐ WIL ☐ WF ☐ LS ☐ GOV ☐ REG2/3 ☐ JDC-LT ☐ KAYS ☐ DIS
☐ Other _____

(*) Requestor Address: Collin County Health Care Services
825 N. McDonald St. McKinney, TX 75069
Ph: (972) 548-5529 Metro (972) 424-1460 ext. 5529

(*) SPECIMEN IS: ☐ Blood ☐ Serum

TEST PURPOSE: ☐ Prenatal ☐ Diagnostic ☐ Treatment Control

(*) TEST REQUEST: ☐ RPR Card
☐ TP-PA if RPR card is reactive
☐ TP-PA regardless of RPR Card results –Justification(Specify) _____

LABORATORY REPORT (DO NOT WRITE BELOW)

NOTE:TECH ID FOUND ON DAILY WORKSHEET/TAPE

RPR RESULTS ☐ Nonreactive ☐ Reactive ☐ Titer 1: ____
☐ Minimally Reactive (undiluted only)

TPPA RESULT ☐ Nonreactive ☐ Reactive ☐ Indeterminate

TO DSHS: ☐ FTA ☐ IgG-EIA DATE SENT: __ / __ / ____ DATE RECIEVED: __ / __ / ____

DSHS RESULT ☐ NR ☐ R ☐ ID

UNSATISFACTORY
☐ Broken in mail ☐ QNS ☐ Hemolyzed ☐ Turbid ☐ No specimen Received ☐ Name Discrepancy ☐ Other _____

COMMENTS:

Rev(11/04)

Collin County

Bid 12108-10

GONORRHEA/CHLAMYDIA SCREEN

Form No: GC/GP

56650

☐ CORRECTED REPORT

DOCUMENT USED IN : CC STD CLINIC

TESTING LAB:
☐ Dallas Co.Hlth/Hum.Svcs.Laboratory CLIA#45D0672012
☐ Dallas Co.Hlth/Hum.Svcs.MOBILE CLIA#45D0994679

LAB #: DATE CHECKED IN: DATE REPORTED:

DO NOT MARK ABOVE THIS LINE. PRINT BELOW WITH BLACK BALLPOINT OR TYPEWRITER. ASTERISKED(*) INFORMATION MUST BE PROVIDED BY SUBMITTER. PLEASE FILL IN THE DATA USING THE UPPERCASE CHARACTERS.

PATIENT LABEL:

PLACE THE LABEL INSIDE THIS BOX

FUNDING
☐ Title V
☐ Title X
☐ Title XX
☐ Medicaid

(*) SEX
☐ MALE
☐ FEMALE

(*) ETHNICITY
☐ Hisp
☐ NonHisp

RACE
☐ A ☐ AI ☐ B ☐ MR ☐ W

(*) DATE COLLECTED
__ / __ / ____

(*) FP SITE:
☐ BF ☐ DH ☐ ED ☐ GAR ☐ GP ☐ LJ ☐ MP ☐ OW ☐ VIC ☐ Other _____

(*) LAST NAME

(*) FIRST NAME M.I. (*) BIRTH DATE __ / __ / ____

STREET

APT NO CITY STATE ZIP CODE

SSN ___ - __ - ____ PHONE# (___) - ___ - ____
Area Code

(*) Send Report to:
☐ COL CO ☐ CD ☐ EH ☐ MV ☐ NT-HRC ☐ REF ☐ T&C ☐ TB ☐ WIL ☐ WF ☐ LS ☐ GOV ☐ REG2/3 ☐ JDC-LT ☐ KAYS ☐ DIS

☐ Other _____

Requestor: Address:
Collin County Health Care Services
825 N. McDonald St. McKinney, TX 75069
Ph: (972) 548-5529 Metro (972) 424-1460 ext. 5529

(*) SOURCE:

CULTURAL METHOD: ☐ Cervix ☐ Urethra ☐ Throat ☐ Vagina ☐ Rectum ☐ Other _____

NONCULTURAL METHOD: ☐ Cervix ☐ Urethra ☐ Eye(Chlamydia ONLY) ☐ Urine

LABORATORY REPORT(DO NOT WRITE BELOW)

NOTE:TECH ID FOUND ON DAILY WORKSHEET/TAPE

☐ POSITIVE TEST for Neisseria gonorrhoeae
☐ NEGATIVE TEST for Neisseria gonorrhoeae
☐ Unsatisfactory--GC Unable to complete testing

☐ POSITIVE TEST for Chlamydia Trachomatis
☐ NEGATIVE TEST for Chlamydia Trachomatis
☐ Unsatisfactory--CT Unable to complete testing

☐ DRUG SUSCEPTIBILITY (see Comments if checked)

☐ UNSATISFACTORY --Please Resubmit
☐ Delay in Shipment ☐ Name Discrepancy ☐ No Name on Specimen ☐ Overgrown ☐ Other(Specify) _____

COMMENTS:

Rev (11/04)

61306

DOCUMENT USED IN : CC STD CLINIC

HIV
Form No:HIV

TESTING LAB:
☐ Dallas Co.Hlth/Hum.Svcs.Laboratory CLIA#45D0672012
☐ Dallas Co.Hlth/Hum.Svcs.MOBILE CLIA#45D0994679

☐ **CORRECTED REPORT**

LAB #: **DATE CHECKED IN:** **DATE REPORTED:**

DO NOT MARK ABOVE THIS LINE. PRINT BELOW WITH BALLPOINT OR TYPEWRITER. ASTERISKED(*)INFORMATION MUST BE PROVIDED BY SUBMITTER. PLEASE FILL IN THE DATA USING THE UPPERCASE CHARACTERS.

PATIENT LABEL:

PLACE THE LABEL INSIDE THIS BOX

FUNDING
☐ Title V
☐ Title X
☐ Title XX
☐ Medicaid

(*) SEX
☐ MALE
☐ FEMALE

(*) ETHNICITY
☐ Hisp
☐ NonHisp

(*) RACE
☐ A ☐ AI ☐ B ☐ MR ☐ W

(*) DATE COLLECTED
__ / __ / ____

(*) FP SITE:
☐ BF ☐ DH ☐ ED ☐ GAR ☐ GP ☐ SE ☐ MP ☐ OW ☐ VIC ☐ Other _____

(*) LAST NAME

(*) FIRST NAME **M.I.** **(*) BIRTH DATE** __ / __ / ____

STREET

APT NO **CITY** **STATE** **ZIP CODE**

SSN ___ - __ - ____ **PHONE#** ___ - ___ - ____
Area Code

(*) Send Report to:
☐ COL CO ☐ CD ☐ EH ☐ MV ☐ NT-HRC ☐ REF ☐ T&C ☐ TB ☐ WIL ☐ WF ☐ LS ☐ GOV ☐ REG2/3 ☐ JDC-LT ☐ KAYS ☐ DIS

☐ Other _____

(*) Requestor Address: Collin County Health Care Services
825 N. McDonald St McKinney, TX 75069
Ph: (972) 548-5520 Metro (972) 424-1460 ext. 5529

(*) SPECIMEN IS: ☐ Blood ☐ Oral Fluid ☐ Other

ADDITIONAL INFORMATION:

LABORATORY REPORT(DO NOT WRITE BELOW)

TEST RESULTS:	Nonreactive	Reactive
☐ HIV-1 EIA	☐	☐
☐ HIV-1 + O EIA	☐	☐
☐ HIV-1/2 + O EIA	☐	☐
☐ HIV-2 EIA	☐	☐
☐ RAPID HIV	☐	☐
☐ IFA	☐	☐

NOTE:TECH ID FOUND ON RESULTS PRINTOUT OR WB WORKSHEET

WB Reviewed by:

Reviewed Date: __ / __ / ____

WB RESULTS:

BANDS:	Present	Absent
gp160	☐	☐
gp120	☐	☐
p65	☐	☐
p51/55	☐	☐
gp41	☐	☐
gp40	☐	☐
p31	☐	☐
p24	☐	☐
p18	☐	☐

☐ UNSATISFACTORY SPECIMEN -Please Specify

INTERPRETATION:

☐ **REACTIVE WB** If the risk factors and immune assessment results of this patient are inconsistent with the first time reactive WB result,a followup specimen should be submitted to rule out a false result

☐ **INDETERMINATE WB** The banding pattern does NOT meet CDC's or kit manufacturer's criteria for reactive. Submit a new specimen in two(2) months to clarify indeterminate results

Rev (11/04)

DOCUMENT USED IN : CC STD CLINIC

CCHCS – STD CLINIC (FEMALE CHART) PATIENT NAME: _____ ____AGE

REASON FOR VISIT

- ☐ SYMPTOMS
- ☐ ASYMPTOMATIC
- ☐ STD SCREEN
- ☐ HIV TEST
- ☐ F/U _____
- ☐ FIELD RECORD
- ☐ OTHER _____

NOTES:

+LAB / CONTACT TO:

- ☐ CHLAMYDIA
- ☐ GC
- ☐ RPR
- ☐ VDRL
- ☐ MHA
- ☐ OTHER

REFERRAL FROM:
- ☐ PVT. DR.
- ☐ PARKLAND
- ☐ _____FP
- ☐ OTHER

DATE: _____

- ☐ CHANCROID
- ☐ CHLAMYDIA
- ☐ GC
- ☐ HIV
- ☐ MPC
- ☐ PID
- ☐ SYPHILIS _____
- ☐ TRICH
- ☐ UNK STD
- ☐ OTHER

PAST MEDICAL HISTORY

☐ NO CHANGE SINCE LAST VISIT

ALLERGIES
☐ NO ☐ YES
_____
_____

CHRONIC MEDS:
_____
_____

CHRONIC DISEASE:
_____
_____

MEDS (1mo.):
_____
_____

☐ TB

SURG/HOSP:

☐ DRUGS _____
☐ IVDU _____
☐ G____ P____ Ab____

LMP: _____
☐ WNL ☐ ABNL
☐ DOUCHING

PRIOR STDs

- ☐ NONE
- ☐ CHANCROID
- ☐ CHLAMYDIA
- ☐ GONORRHEA
- ☐ HEP B
- ☐ HERPES
- ☐ HIV
- ☐ HPV
- ☐ LGV
- ☐ MPC
- ☐ NGU
- ☐ PID
- ☐ TRICH
- ☐ OTHER

SYPHILIS
☐ _____
☐ OTHER:

SEXUAL HISTORY

☐ NO CHANGE SINCE LAST VISIT

LAST SEXUAL CONTACT:
DATE: _____

OF SEX PARTNERS IN THE PAST _____ MONTH(S):_____

☐ MALE _____
☐ FEMALE _____

BIRTH CONTROL:
- ☐ CONDOM
- ☐ DEPO-PROVERA
- ☐ HYSTERECTOMY
- ☐ IMPLANT
- ☐ IUD
- ☐ PILL
- ☐ SPERMICIDE
- ☐ TUBAL
- ☐ NUVA RING
- ☐ PATCH

CONTACT PROBLEM:
☐ NO ☐ YES
☐ UNK ☐ HERE

DX:

NEW IN THE PAST MONTH:
☐ NO ☐ YES

EXPOSURE SITES:
- ☐ GENITAL
  CONDOM Y N
- ☐ ORAL
  CONDOM Y N
- RECTAL
  ☐ ACTIVE
  CONDOM Y N
  ☐ PASSIVE
  CONDOM Y N

LAST PAP:
- ☐ NONE
- ☐ < 1 YEAR
- ☐ > 1 YEAR

PLACE:

SUBJECTIVE SYMPTOMS:

- ☐ NONE _____
- ☐ RASH _____
- ☐ DISCHARGE _____
- ☐ WARTS _____
- ☐ LESION _____
- ☐ ITCHING _____
- ☐ DYSURIA _____
- ☐ ABD. PAIN _____
- ☐ ODOR _____
- ☐ OTHER _____

PHYSICAL EXAM ☐ NOT DONE

PATIENT ALSO EXAMINED BY: _____

ORO-PHARYNX

- ☐ NOT DONE
- ☐ WNL
- ☐ ULCER
- ☐ EXUDATE
- ☐ INFLAMED
- ☐ OTHER

_____
TEMP: _____

PUBIC HAIR

- ☐ NOT DONE
- ☐ WNL
- ☐ CRABS
- ☐ FOLLICULITIS
- ☐ SHAVED
- ☐ OTHER

_____
_____

LYMPH NODES

	CRV R	CRV L	AXL R	AXL L	ING R	ING L	FEM R	FEM L
WNL	☐	☐	☐	☐	☐	☐	☐	☐
ENLARGED	☐	☐	☐	☐	☐	☐	☐	☐
TENDER	☐	☐	☐	☐	☐	☐	☐	☐

BIMANUAL

- ☐ NOT DONE
- ☐ WNL
- ☐ CMT
- ☐ ENLARGED UTERUS
- ☐ UTERUS ABSENT
- ☐ UTERINE TENDERNESS

ADNEXAL TENDERNESS
☐ RIGHT ☐ LEFT

ADNEXAL MASS
☐ RIGHT ☐ LEFT

SKIN

- ☐ NOT DONE
- ☐ WNL
- ☐ P&P RASH
- ☐ FOLLICULITIS
- ☐ MOLLUSCUM
- ☐ OTHER

_____

- ☐ RASH
- ☐ SCABIES
- ☐ TINEA CRURIS
- ☐ WARTS
- ☐ TATTOO _____
- ☐ PIERCINGS

_____

VULVA / VAGINA

- ☐ WNL
- ☐ PH: _____
- ☐ ERYTHEMA
- ☐ VESICLE
- ☐ ULCER
- ☐ HEALED LESION
- ☐ FOLLICULITIS
- ☐ RASH
- ☐ WART
- ☐ BARTHOLIN CYST

- ☐ NO DISCHARGE
- ☐ DISCHARGE
  - ☐ SMALL
  - ☐ MODERATE
  - ☐ LARGE
  - ☐ CLEAR
  - ☐ CLOUDY
  - ☐ PUS
  - ☐ BLOODY
  - ☐ MUCOUS
  - ☐ WHITE
  - ☐ YELLOW

URETHRA:
- ☐ WNL
- ☐ DISCHARGE

ABDOMEN

- ☐ WNL
- ☐ REBOUND
- ☐ GUARDING
- ☐ OTHER

ANUS

- ☐ NOT DONE
- ☐ WNL
- ☐ DISCHARGE
- ☐ ULCER
- ☐ FISSURE
- ☐ WART
- ☐ HEMORRHOID
- ☐ OTHER

CERVIX

- ☐ NOT DONE
- ☐ WNL
- ☐ ABSENT
- ☐ FRIABLE
- ☐ ULCER
- ☐ POLYP
- ☐ VESICLE
- ☐ NO DISCHARGE
- ☐ DISCHARGE
- ☐ SMALL
- ☐ MODER
- ☐ LARGE

COLLIN COUNTY HEALTH CARE SERVICES – STD CLINIC (FEMALE CHART) cont.

DOCUMENT USED IN : CC STD CLINIC

STAT LABORATORY

- ☐ NOT AVAILABLE ☐ CLUE CELLS ☐ WBC
- ☐ SPORES ☐ HYPHAE
- ☐ WHIFF TEST: ☐ POS ☐ NEG
- ☐ WET PREP: TRICH ☐ POS ☐ NEG
- ☐ PREGNANCY TEST (URINE) ☐ POS ☐ NEG

HIV RISK FACTORS

SINCE YOU HAVE BECOME SEXUALLY ACTIVE:

- ☐ HAD SEX WITH A MALE / FEMALE
- ☐ USED INJECTABLE DRUGS
- ☐ SHARED NEEDLES
- ☐ HAD SEX WHILE USING NON-INJ. DRUGS
- ☐ EXCHANGED SEX FOR DRUGS / MONEY
- ☐ HAD A HEALTH CARE EXPOSURE OR

HAVE YOU HAD SEX WITH A:

- ☐ MAN WHO HAD SEX WITH A MAN
- ☐ PERSON WITH HEPATITIS B
- ☐ PERSON WITH HIV / AIDS
- ☐ PERSON W/ OTHER HIV / AIDS RISK
- ☐ IDU

OR ARE YOU A:

- ☐ HEMOPHILIAC / BLOOD RECIPIENT
- ☐ CHILD OF WOMAN WITH HIV / AIDS
- ☐ VICTIM OF SEXUAL ASSAULT
- ☐ NO ACKNOWLEDGED RISK

LABORATORY PENDING

- ☐ CHANCROID CULTURE
- GONORRHEA CULTURE
  - ☐ THROAT _____
  - ☐ URETHRAL _____
  - ☐ RECTAL _____
  - ☐ EYE _____
- ☐ GENPROBE
  - ☐ URINE ☐ CERVIX
- ☐ HIV
- ☐ RPR
- ☐ HSV & IGG
- ☐ HERPES CULTURE
- ☐ TP-PA
- ☐ ACUTE HEPATITIS PROFILE
- ☐ OTHER _____

COUNSELING

- ☐ CONTACT NOTIFICATION SLIPS GIVEN ☐ YES ☐ NO
- ☐ PATIENT ADVISED ABOUT HIV TEST
- ☐ PATIENT COUNSELED ABOUT INFECTION, TREATMENT, & PREVENTION. ABSTAIN FROM SEX UNTIL ALL PARTNERS TREATED.
- ☐ RECOMMENDED HEP A / HEP B VACCINE
- ☐ DISCUSSED RESULTS & PREVENTION OF STD'S
- ☐ CONDOM AT ALL TIMES FOR SAFE SEXUAL PRACTICES
- ☐ MEDICATION: _____
- ☐ LITERATURE: _____
- ☐ GARDASIL:
- ☐ HIV: ☐ 3 MONTHS ☐ 6 MONTHS

NOTES:

IMPRESSIONS

- ☐ NO APPARENT STD

	F/U
☐ CANDIDA	☐
☐ CHANCROID	☐
☐ CHLAMYDIA	☐
☐ EPIDIDYMITIS	☐
☐ FOLLICULITIS	☐
☐ GEN ULCER DIS	☐
☐ GONORRHEA	☐
☐ HERPES	☐
☐ HIV	☐
☐ HPV	☐
☐ LGV	☐
☐ MOLLUSCUM	☐
☐ NGU	☐
☐ PEDIC PUBIS	☐
☐ SCABIES	☐
SYPHILIS	
☐ PRIMARY	☐
☐ SECONDARY	☐
☐ EL	☐
☐ LL	☐
☐ CONGENITAL	☐
☐ BFP	☐
☐ SEROFAST	☐
☐ TINEA CRURIS	☐
☐ TRICH	☐
☐ BACTERIAL VAG.	☐
☐ CERVICITIS	☐

DISPOSITION

- ☐ REFERRAL TO: _____
- ☐ PAP ASAP
- ☐ RTC IF PROBLEM RECURS
- ☐ CALL FOR RESULTS

F/U APPT. FOR or RTC FOR TR:

- ☐ RECHECK _____
- ☐ TX _____
- ☐ RPR _____
- ☐ TOC _____
- ☐ HEP A #2 _____
- ☐ HEP B #2 _____ #3 _____
- ☐ GARDASIL #2 ____ #3 ____

PATIENT WALKED

CHOOSE ONLY ONE ANSWER:

- ☐ NOT SEEN
- ☐ NO Rx
- ☐ NO INTERVIEW
- ☐ INTERPRETER

TREATMENT

- ☐ NONE ☐ EPI TREAT
- ☐ ACYCLOVIR
- ☐ AZITHROMYCIN 1 GM
  - ☐ HOME ☐ NOW
- ☐ BICILLIN* 2.4MU IM, div R&L, _____ : _____
- ☐ CEFTRIAXONE* 125mg IM, R/L DELT, ___ : ___
- ☐ CEFTRIAXONE* 250mg IM, R/L DELT, ___ : ___
- ☐ VANTIN 200MG x2 TAB NOW
- ☐ DOXCYCLINE 100mg bid x days:
  - ☐ 7 ☐ 10 ☐ 14 ☐ 21 ☐ 28
- ☐ ERYTHROMYCIN 250mg ☐ (2) qid x days
  - ☐ 7 ☐ 10 ☐ 14 ☐ 21 ☐ 28
- ☐ LIQUID NITROGEN APPLIED BY: _____
- ☐ METRONIDAZOLE 500mg #4
- ☐ METRONIDAZOLE 500mg #14 BID X 7 days
- ☐ OTC ANTIFUNGAL/YEAST MEDICATION
- ☐ OTC PEDICULOCIDE
- ☐ SUPRAX 400MG ☐ NOW
- ☐ TRICHLOROACETIC ACID APPLIED BY: _____
- ☐ OTHER _____
- ☐ OUT OF EXPOSURE PERIOD
- ☐ INSTRUCTED TO STAY 30 MINS. POST INJECTION
- ☐ HEP A VACCINE ☐ ACCEPT ☐ DECLINE
- ☐ HEP B VACCINE ☐ ACCEPT ☐ DECLINE
- ☐ GARDASIL ☐ ACCEPT ☐ DECLINE
- ☐ Completed Hep A series per patient.
- ☐ Completed Hep B series per patient.
- ☐ Completed Gardasil series per patient.

1. PRETEST COUNSELED/CONSENT (Obtained for HIV and all tests)
☐ YES ☐ NO

2. TESTED FOR HIV?
☐ YES ☐ NO

3. POST-TEST COUNSELED?
☐ YES ☐ NO

4. PREVIOUS HIV TEST?
☐ NO ☐ (R) ☐ (NR < 3MO)
☐ (NR > 3MO) ☐ UNKNOWN
DATE: _____/_____/_____
PROVIDER: _____

☐ CONSULTED: _____

COMMENTS:

_____
_____
_____
_____
_____

REVIEWED BY: _____ **MD/DO** **DATE:** _____
STD CLINICIAN: _____ **DATE:** _____

DOCUMENT USED IN : CC STD CLINIC

CCHCS – STD CLINIC (MALE CHART) PATIENT NAME: _____ ____AGE

REASON FOR VISIT

- ☐ FIELD RECORD
- ☐ SYMPTOMS
- ☐ HIV TEST
- ☐ STD SCREEN
- ☐ F/U _____
- ☐ OTHER _____
- ☐ FIELD BLOOD ONLY

NOTES:

+LAB / CONTACT TO:

- ☐ CHLAMYDIA
- ☐ GC
- ☐ RPR
- ☐ VDRL
- ☐ MHA
- ☐ OTHER

REFERRAL FROM:

- ☐ PVT. DR.
- ☐ PARKLAND
- ☐ _____FP
- ☐ OTHER

DATE: _____

- ☐ CHANCROID
- ☐ CHLAMYDIA
- ☐ GC
- ☐ HIV
- ☐ MPC
- ☐ PID
- ☐ SYPHILIS _____
- _____
- ☐ TRICH
- ☐ UNK STD
- ☐ OTHER

PAST MEDICAL HISTORY

☐ NO CHANGE SINCE LAST VISIT

ALLERGIES
☐ **NO** ☐ **YES**
_____
_____

CHRONIC MEDS:
_____
_____

CHRONIC DISEASE:
_____
_____

MEDS (1mo.):
_____
_____

☐ TB

SURG/HOSP:
_____
_____

☐ DRUGS _____
☐ IVDU _____

PRIOR STDs

- ☐ NONE
- ☐ CHANCROID
- ☐ CHLAMYDIA
- ☐ EPIDIDYMITIS
- ☐ GONORRHEA
- ☐ HEP B
- ☐ HERPES
- ☐ HIV
- ☐ HPV
- ☐ LGV
- ☐ NGU
- ☐ TRICH
- ☐ OTHER

SYPHILIS
☐ _____
☐ OTHER
_____
_____

SEXUAL HISTORY

☐ NO CHANGE SINCE LAST VISIT

LAST SEXUAL CONTACT:
DATE: _____

 # OF SEX PARTNERS IN THE PAST 6 MONTH(S):_____

- ☐ MALE _____
- ☐ FEMALE _____

BIRTH CONTROL:

- ☐ ABSTINENCE
- ☐ NONE
- ☐ CONDOM
- ☐ VASECTOMY
- ☐ SPERMICIDE
- ☐ OTHER

CONTACT PROBLEM:
☐ NO ☐ YES
☐ UNK ☐ HERE
DX:

NEW IN THE PAST MONTH:
☐ NO ☐ YES

EXPOSURE SITES:

☐ **GENITAL**
CONDOM Y N
☐ **ORAL**
CONDOM Y N
RECTAL
☐ **ACTIVE**
CONDOM Y N
☐ **PASSIVE**
CONDOM Y N

NOTES:

SUBJECTIVE SYMPTOMS:

- ☐ NONE _____
- ☐ RASH _____
- ☐ DISCHARGE _____
- ☐ WARTS _____
- ☐ LESION _____
- ☐ ITCHING _____
- ☐ DYSURIA _____
- ☐ ABD. PAIN _____
- ☐ OTHER _____

PHYSICAL EXAM ☐ NOT DONE

PATIENT ALSO EXAMINED BY:

ORO-PHARYNX

- ☐ NOT DONE
- ☐ WNL
- ☐ ULCER
- ☐ EXUDATE
- ☐ INFLAMED
- ☐ OTHER

_____
TEMP: _____

PUBIC HAIR

- ☐ NOT DONE
- ☐ WNL
- ☐ CRABS
- ☐ FOLLICULITIS
- ☐ SHAVED
- ☐ OTHER

_____
_____

SKIN

- ☐ NOT DONE
- ☐ WNL
- ☐ P&P RASH
- ☐ FOLLICULITIS
- ☐ MOLLUSCUM
- ☐ OTHER

_____

- ☐ RASH
- ☐ SCABIES
- ☐ TINEA CRURIS
- ☐ WARTS
- ☐ TATTOO _____
- ☐ PIERCINGS

_____

ABDOMEN

- ☐ WNL
- ☐ REBOUND
- ☐ GUARDING
- ☐ OTHER _____

_____
_____

LYMPH NODES

	CRV R	CRV L	AXL R	AXL L	ING R	ING L	FEM R	FEM L
WNL	☐	☐	☐	☐	☐	☐	☐	☐
ENLARGED	☐	☐	☐	☐	☐	☐	☐	☐
TENDER	☐	☐	☐	☐	☐	☐	☐	☐

PENIS

- ☐ NOT DONE
- ☐ CIRCUMCISION: Y N
- ☐ WNL
- ☐ HYPOSPADIAS
- ☐ ULCER
- ☐ HEALED LESION
- ☐ VESICLE
- ☐ FOLLICULITIS
- ☐ RASH
- ☐ WART
- ☐ BALANITIS
- ☐ OTHER _____

- ☐ NO DISCHARGE
- ☐ DISCHARGE
  - ☐ SMALL
  - ☐ MODERATE
  - ☐ LARGE
- ☐ CLEAR
- ☐ CLOUDY
- ☐ PUS
- ☐ BLOODY
- ☐ MUCOUS
- ☐ YELLOW

NOTES:

SCROTAL CONTENTS

☐ NOT DONE

R	L	
☐	☐	WNL
☐	☐	TESTICULAR TENDERNESS
☐	☐	ABSENT
☐	☐	EPIDIDYMITIS
☐	☐	HERNIA
☐	☐	HYDROCELE
☐	☐	MASS
☐	☐	VARICOCELE
☐	☐	OTHER

ANUS

- ☐ NOT DONE
- ☐ WNL
- ☐ DISCHARGE
- ☐ ULCER
- ☐ OTHER: _____

- ☐ FISSURE
- ☐ WART
- ☐ HEMORRHOID

_____
_____
_____

COLLIN COUNTY HEALTH CARE SERVICES – STD CLINIC (MALE CHART) cont.

STAT LABORATORY

DOCUMENT USED IN : CC STD CLINIC

☐ NOT AVAILABLE

☐ WET PREP: TRICH POS. NEG.

☐ WHIFF TEST: POS. NEG.

☐ URINALYSIS: DIP STICK YES NO
GLUCOSE _____ NITRITES _____
PROTEIN _____ LEUKOCYTES _____
BLOOD _____

HIV RISK FACTORS

SINCE YOU HAVE BECOME SEXUALLY ACTIVE:

☐ HAD SEX WITH A MALE / FEMALE
☐ USED INJECTABLE DRUGS
☐ SHARED NEEDLES
☐ HAD SEX WHILE USING NON-INJ. DRUGS
☐ EXCHANGED SEX FOR DRUGS / MONEY
☐ HAD A HEALTH CARE EXPOSURE OR HAVE YOU HAD SEX WITH A:
☐ MAN WHO HAD SEX WITH A MAN
☐ PERSON WITH HEPATITIS B
☐ PERSON WITH HIV / AIDS
☐ PERSON W/ OTHER HIV / AIDS RISK
☐ IDU
OR ARE YOU A:
☐ HEMOPHILIAC / BLOOD RECIPIENT
☐ CHILD OF WOMAN WITH HIV / AIDS
☐ VICTIM OF SEXUAL ASSAULT
☐ NO ACKNOWLEDGED RISK

LABORATORY PENDING

☐ CHANCROID CULTURE
GONORRHEA CULTURE
☐ THROAT _____
☐ URETHRAL _____
☐ RECTAL _____
☐ EYE _____

☐ GENPROBE
☐ HSVI & IGG
☐ HERPES CULTURE
☐ HIV
☐ TP-PA
☐ HEPATITIS PROFILE
☐ RPR _____
☐ OTHER_____

IMPRESSIONS

☐ NO APPARENT STD

	F/U
☐ CANDIDA	☐
☐ CHANCROID	☐
☐ CHLAMYDIA	☐
☐ EPIDIDYMITIS	☐
☐ FOLLICULITIS	☐
☐ GEN ULCER DIS	☐
☐ GONORRHEA	☐
☐ HERPES	☐
☐ HIV	☐
☐ HPV	☐
☐ LGV	☐
☐ MOLLUSCUM	☐
☐ NGU	☐
☐ PEDIC PUBIS	☐
☐ SCABIES	☐
SYPHILIS	
☐ PRIMARY	☐
☐ SECONDARY	☐
☐ EL	☐
☐ LL	☐
☐ CONGENITAL	☐
☐ BFP	☐
☐ SEROFAST	☐
☐ TINEA CRURIS	☐
☐ TRICH	☐
☐ OTHER _____	☐

TREATMENT

☐ NONE ☐ EPI TREAT
☐ ACYCLOVIR
☐ AZITHROMYCIN 1 GM
☐ HOME ☐ NOW
☐ BICILLIN* 2.4MU IM, div R&L, _____ : _____
☐ CEFTRIAXONE* 125mg IM, R/L DELT, ___: ___
☐ CEFTRIAXONE* 250mg IM, R/L DELT, ___: ___
☐ VANTIN 200MG TI NOW
☐ DOXCYCLINE 100mg bid x days:
☐ 7 ☐ 10 ☐ 14 ☐ 21 ☐ 28
☐ ERYTHROMYCIN 250mg ☐ (2) qid x days
☐ 7 ☐ 10 ☐ 14 ☐ 21 ☐ 28
☐ LIQUID NITROGEN APPLIED BY: _____
☐ METRONIDAZOLE 500mg #4
☐ METRONIDAZOLE 500mg #14 BID X 7 days
☐ OTC ANTIFUNGAL/YEAST MEDICATION
☐ OTC PEDICULOCIDE
☐ SUPRAX 400MG ☐ NOW
☐ TRICHLOROACETIC ACID APPLIED BY:
_____
☐ OTHER _____
☐ OUT OF EXPOSURE PERIOD
☐ INSTRUCTED TO STAY 30 MINS. POST INJECTION
☐ HEP A VACCINE ☐ ACCEPT ☐ DECLINE
☐ HEP B VACCINE ☐ ACCEPT ☐ DECLINE
☐ Completed Hep A series per patient.
☐ Completed Hep B series per patient.

DISPOSITION

☐ REFERRAL TO:
_____
☐ Call for lab results, RTC if problem recurs
☐ Call for test results

F/U APPT. FOR or RTC FOR TR:
☐ RECHECK _____
☐ TX _____
☐ RPR _____
☐ TOC _____
☐ HEP A #2 _____
☐ HEP B #2 ____ #3 ____

1. PRETEST COUNSELED/CONSENT (Obtained for HIV and all tests)
☐ YES ☐ NO
2. TESTED FOR HIV?
☐ YES ☐ NO
3. POST-TEST COUNSELED?
☐ YES ☐ NO
4. PREVIOUS HIV TEST?
☐ NO ☐ (R) ☐ (NR < 3MO)
☐ (NR > 3MO) ☐ UNKNOWN
DATE: _____/_____/_____
PROVIDER: _____

COUNSELING

CONTACT NOTIFICATION SLIPS GIVEN YES NO

☐ PATIENT ADVISED ABOUT HIV TEST ☐3MOS. ☐6MOS.
☐ PATIENT COUNSELED ABOUT INFECTION, TREATMENT, & PREVENTION. ABSTAIN FROM SEX UNTIL ALL PARTNERS TREATED.
☐ RECOMMENDED HEP A / HEP B VACCINE
☐ DISCUSSED RESULTS & PREVENTION OF STD'S
☐ CONDOM AT ALL TIMES FOR SAFE SEXUAL PRACTICES
☐ MEDICATION: _____
☐ LITERATURE: _____

☐ CONSULTED: _____
COMMENTS:
_____
_____
_____
_____
_____

REVIEWED BY: _____ **MD / DO** **DATE:** _____

STD CLINICIAN: _____ **DATE:** _____

PATIENT WALKED

CHOOSE ONLY ONE ANSWER:
☐ NOT SEEN ☐ NO Rx
☐ NO INTERVIEW ☐ INTERPRETER

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

Refusal of Services

I, _____, hereby release Collin County Health Care Services, its physicians, and nurses from all responsibility for any complications which may arise as a result of my refusing _____.
I acknowledge that I have been fully informed of and understand the above treatment or recommendations and the risk(s) involved in refusing. I hereby release and agree to hold harmless Collin County Health Care Services, and its employees and agents from all responsibility and ill effect which may result from this action. I also acknowledge that I have been fully informed of and understand that I may have medical problems that may go undetected and untreated as a result of this refusal.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Yo, _____, por la presente cedo el Departamento de salud de Collin County, sus medicos y enfermerosias de todo responsabilidades por cualquier complicación qe pueda pasar por el resultado de min negacion _____.
Reconozco que me han informado completamente y entiendo el tratamiento o las recomendaciones antedichas y los riesgos implicados en el rechazo. Lanzo por este medio y acuerdo llevar a cabo servicios inofensivos del cuidado médico del condado de Collin, y sus empleados y agentes de toda la responsabilidad y efecto perjudicial que puedan resultar de esta acción. También reconozco que me han informado completamente y entiendo que puedo tener problemas médicos que puedan ir desapercibidos y untreated como resultado de esta denegación.

_____ _____
Firma, Paciente Fecha

_____ _____
Firma, Testigo Fecha

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

DOCUMENT USED IN :
CC STD CLINIC

TREATMENT AND FOLLOW-UP

PATIENT NAME:_____

DOB: _____/____/_____

DATE: _____/____/_____

INITIAL LAB RESULTS: **HIV** **RPR** **TPPA**

DIAGNOSIS: _____

Treatment:

1)_____

2) _____

3) _____

FOLLOW-UP DATE --	**LAB RESULTS: HIV**	**RPR**
_____/_____/_____		
_____/_____/_____		
_____/_____/_____		
_____/_____/_____		
_____/_____/_____		
_____/_____/_____		
_____/_____/_____		
_____/_____/_____		

I, _____, have been informed of the above follow-up to ensure proper treatment of syphilis. Syphilis can be very harmful for both women and men if it is not treated early. It ***may cause arthritis, blindness, heart disease, mental illness or even death.*** It may affect both you and your partner. The only way to ensure proper treatment is to get a follow-up blood work as recommended by the Center for Disease Control. By my signature shown below, I acknowledge that I understand the importance of returning to CCHCS on the dates shown above for treatment.

I hold harmless and release Collin County, Collin County Health Care Services (CCHCS), Belsy Koruthu, WHNP, and Muriel Marshall, D.O., of any liability for any adverse events, mental duress, or adverse outcomes in health.

_____ (Patient Initials) I have received a copy of the Treatment and Follow Up form.

_____ _____
Signature Date

_____ _____
Witness Date

9/18/08

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: _

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: Michael Hale, PA-C

Type of practice / Medical specialty: Primary Care

Telephone: (972) 5485532 Fax:(972) 5485550

CONTINUED ON NEXT PAGE

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   No ___Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   prolonged walking, lifting using legs, standing, climbing

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary?
   ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups?
   ____ No ____Yes. If so, explain:

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

TEXAS COMMISSION ON LAW ENFORCEMENT
OFFICER STANDARDS AND EDUCATION
6330 U.S. Highway 290 East, Suite 200
Austin, Texas 78723
Phone: (512) 936-7700
http://www.tcleose.state.tx.us

L-2
DECLARATION OF MEDICAL CONDITION
Commission Rule §217.1(a)(11)

APPLICANT INFORMATION

1. First Name	2. M. I.	3. Last Name	4. Suffix (Jr., etc.)	5. TCLEOSE PID or SSN

6. Home Mailing Address	7. City	8. State	9. Zip Code

APPOINTMENT AND DEPARTMENT INFORMATION

10. ☐ Peace Officer ☐ Reserve Officer ☐ Temp/County Jailer ☐ Public Security Officer

11. TCLEOSE Agency Number	12. Appointing Agency	13. Agency Mailing Address

14. City	15. County	16. Zip Code	17 Phone Number

Attention Examining Professional: The above information must be completed by the requesting agency prior to the examining professional completing and signing this form.

I certify that I have completed my examination of the examinee and I have concluded that on this date, the examinee is found:

NEW APPLICANTS MUST COMPLETE BOTH EXAMS
180 DAY BREAK IN SERVICE NEEDS DRUG SCREEN ONLY

Check the appropriate box(s)

☐ **PHYSICAL EXAM** -To be physically sound and free from any defect which may adversely affect the performance of duty appropriate to the type of license sought.

☐ **DRUG SCREEN** - To show no trace of drug dependency or illegal drug use after a physical examination, blood test or other medical test.

Physician:_____
Printed Name State License Number

Mailing Address:_____
Street City State Zip

Phone Number:_____

_____
Date of Examination(s) Signature Date

THIS DECLARATION IS NOT PUBLIC INFORMATION AND IS VALID UNLESS WITHDRAWN OR INVALIDATED, AND IS VALID ONLY IF SIGNED BY A LICENSED PHYSICIAN.

DOCUMENT USED IN : CC EMPLOYEE HEALTH

REFERRAL FORM

Attachment H: Mandated Forms

Referral Date: _____

To: Name and Address of Receiving Agency or Person

From: Collin County Employee Clinic
825 N. McDonald St. Ste.130
McKinney, TX. 75069
972-548-5532 Metro: 972-424-1460

Client's Name

Social Security Number

Address

Birthdate Sex (m) (f)

City State Zip Code

Marital Status (S) (M) (W) (D) (Sep) (Unk)

Name of Spouse/ Parent/ Guardian

(____) _____
Telephone (Hm) or (Wk)

REASON FOR REFERRAL:

RETURN RESPONSE REQUESTED

Signature/ Title

Signature signifies receipt/ knowledge of this referral and authorizes the referring agency to release information necessary for its completion, and the referring agency is released from all legal responsibility that may arise from this act.

Signature of Client /Parent/ Guardian

FINDINGS AND SERVICES RENDERED:

1) White – Receiving Agency
2) Yellow – Receiving Agency Response
3) Pink – Client Record

Signature/ Title

Date

Note: Instructions (L-29a) for use of Referral Form should accompany the document.

(TDH) L-29 Rev. (6/91)

DOCUMENT USED IN : CC EMPLOYEE HEALTH

Attachment H: Mandated Forms

DWC FORM-1
(Employer's First Report of Injury or Illness)

The **employer** is required to file an **Employer's First Report of Injury or Illness** [DWC FORM -1 (Rev. 10/05)] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

The **Employer's First Report of Injury or Illness** provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

[Workers' Compensation Rule 120.2]

INSTRUCTIONS FOR EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-1)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Article 8308 - 5.05, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM - 1 (Rev. 10/05) to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty not to exceed $500.00. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Article 8308 -5.04. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Article 8308 - 7.03 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8:	Article 8308 - 2.13(e), Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
Item 4:	If no home phone, please provide a phone number where the employee can be reached.
Items 5,15,17, 26,29,30:	Enter data in month, day, year format. Example: 08-13-54.
Item 18:	List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
Item 19:	List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
Item 20:	Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
Item 22:	State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.
Item 24:	List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
Items 32,33:	Enter date in month-year format. Example: 02-56.
Item 37:	Enter the number of days or hours that make up a full work week for your employees.
Item 45:	Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.
Item 46:	For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.

Attachment H: Mandated Forms

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, Unless the Division specifically requests a direct filling.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex F ☐ M ☐
3. Social Security Number - -
4. Home Phone ( )
5. Date of Birth (m-d-y) - -
6. Does the Employee Speak English? If No, Specify Language YES ☐ NO ☐
7. Race White ☐ Black ☐ Asian ☐
8. Ethnicity Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address Street or P.O. Box
City State Zip Code County
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
11. Number of Dependent Children
12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O.Box)
City State Zip Code
15. Date of Injury (m-d-y) - -
16. Time of Injury : am ☐ pm ☐
17. Date Lost Time Began (m-d-y) - -
18. Nature of Injury*
19. Part of Body Injured or Exposed*
20. How and Why Injury/Illness Occurred*
21. Was employee doing his regular job? YES ☐ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
Street or P.O. Box County
City State Zip Code
24. Cause of Injury(fall, tool, machine, etc.)*
25. List Witnesses
26. Return to work date/or expected (m-d-y) - -
27. Did employee die? YES ☐ NO ☐
28. Supervisor's Name
29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -
31. Was employee hired or recruited in Texas? YES ☐ NO ☐
32. Length of Service in Current Position Months _____ Years _____
33. Length of Service in Occupation Months _____ Years _____
34. Employee Payroll Classification Code
35. Occupation of Injured Worker
36. Rate of Pay at this Job $_____Hourly $_____Weekly
37. Full Work Week is: _____ Hours _____ Days
38. Last Paycheck was: $_____ for ____ Hours or _____ Days
39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form
41. Name of Business
42. Business Mailing Address and Telephone Number
Street or P.O. Box Telephone ( )
City State Zip Code
43. Business Location (If different from mailing address)
Number and Street
City State Zip Code
44. Federal Tax Identification Number
45. Primary North American Industry Classification System Code:(6 digit)
46. Specific NAICS Code (6 digit)
47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company
49. Policy Number
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____

Enteric Disease Investigation Form
for reporting Hemolytic Uremic Syndrome (HUS) and/or *E. coli* O157:H7

DOCUMENT USED IN : CC EPIDEMIOLOGY

Texas Department of Health
Infectious Disease Epidemiology and Surveillance Division
Austin, Texas (512) 458-7676

PATIENT

Name: _____ _____ _____
Last First MI

Address: _____ _____
Street City

_____ _____ _____ (_____) _____
County State Zip Code Phone #

DOB:_____ **Age:**_____ **Sex:** _____ **Race:** _____ (W = white, B = Black, I = Am Indian, A = Asian, H = Hispanic, O = Other)

Occupation: _____
If Day Care, Early Childhood Development, or Food Service position include name and address of employer.

HOUSEHOLD

How many household contacts does the patient have? _____ Have any of these had a diarrheal illness? Yes No
If YES, complete the following information .

Last: _____ First: _____ Onset date: _____ Culture Positive? YES NO

Last: _____ First: _____ Onset date: _____ Culture Positive? YES NO

Last: _____ First: _____ Onset date: _____ Culture Positive? YES NO

Last: _____ First: _____ Onset date: _____ Culture Positive? YES NO

SYMPTOMOLOGY

_____
Onset Date

Check all that apply:

___ Diarrhea

___ Bloody diarrhea

___ Hospitalized Died YES NO

_____ _____
Admit Date Discharge Date

___ Thrombotic thrombocytopenic purpura

___ Hemolytic uremic syndrome (HUS)

LAB DATA

Name/address of Lab:

_____

_____

_____

Organism isolated:

_____

Was isolate sent to TDH for confirmation/PFGE typing?
YES NO

LINKAGE

Prior to and immediately after onset, was the patient:

Associated with another case?

YES NO

Associated with an outbreak?

YES NO

Close contact of another case?

YES NO

TREATMENT

Was the patient treated with antibiotics or antimotility drugs for this illness? YES NO

If YES, complete the following:

Drug	Start date	End date
_____	_____	_____
_____	_____	_____

IDEAS Form 5, 08/98

DOCUMENT USED IN : CC EPIDEMIOLOGY

Attachment H: Mandated Forms

EXPOSURE DATA

Medical Risk Factors (Please check all those that apply)

___ Antibiotic use within 30 days of onset; please name: _____

___ Chronic medications, please name: _____

___ Immunocompromised? If yes, with what? _____

Suspect Foods (Please check all those that apply)

___ Ground beef at home. Brand and Where purchased:_____

___ Other ground beef (ex picnic, barbeque). Where?_____

___ Ground beef from restaurant. Where?_____

___ Raw milk or other unpasteurized dairy products. Please name:_____

___ Unpasteurized fruit juices. Please name:_____

____ Fresh produce from farm or home garden.

____ Sprouts

Food Sample Information

Food samples submitted to TDH? YES NO

Food sample type: _____

Organisms isolated from food: _____ Did food sample PFGE match patient PFGE? YES NO

Other Potential Risk Factors (Please check all those that apply)

___ Contact with diapered children

___ Contact with someone who has diarrhea. Who?_____

___ Exposure to animal waste

____ Recreational water exposure. Where and when?_____

____ Exposure to livestock

____ Exposure to poultry

____ Exposure to exotic pets. Type of pet._____

Does the patient work at or attend a day care center? YES NO

If yes,
Name of day care center: _____ Address: _____

Name of Director: _____ Phone #: _____

Where other children or staff ill? YES NO If YES, were they: Cultured YES NO Excluded from attendance YES NO

COMMENT

Investigated by: _____ Phone: _____
Agency: _____ Date _____

DOCUMENT USED IN : CC EPIDEMIOLOGY

Bacterial Meningitis & Bacteremia Case Report
(Excludes *Haemophilus influenzae* type B Invasive Infections)

PATIENT

Name:_____ _____ _____
Last First MI

Address: _____ _____
Street City

_____ _____ _____ (_____)_____
County State Zip Code Phone #

DOB:_____ Sex: ____ Race: _____ Hispanic Yes No
(W=White, B=Black, I=Am Indian, A=Asian, O=Other)

MEDICAL

DATE OF ONSET: _____ HOSPITALIZED: Yes No If Yes, ADMIT DATE: _____

Hospital Name: _____ Physician Name: _____ Phone: (_____)_____

DIED: Yes No If Yes, DATE OF DEATH: _____

TYPE OF INFECTION CAUSED BY THE ORGANISM (Check all that apply)

___ Primary Bacteremia ___ Meningitis ___ Epiglottitis ___ Septic Arthritis ___ Pericarditis ___ Pneumonia

___ Osteomyelitis ___ Cellulitis ___ Conjunctivitis ___ Otitis media ___ Peritonitis

Other (Specify): _____

LAB DATA

Date When First positive culture obtained: _____

SPECIMEN FROM WHICH ORGANISM WAS ISOLATED: ___ CSF ___ Blood ___ Joint Fluid ___ Pleural Fluid ___ Placenta
___ Pericardial Fluid ___ Peritoneal Fluid ___ Other _____

BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE (Check one) ___ *Neisseria meningitidis* ___ Group A *Streptococcus* ___ *Streptococcus pneumoniae*
___ Group B *Streptococcus* ___ *Listeria monocytogenes*
___ Other (SPECIFY) _____

IF THE ORGANISM ISOLATED WAS *NEISSERIA MENINGITIDIS* , WHAT SEROGROUP? ___ A ___ B ___ C ___ Y ___ W135 ___ Not Groupable ___Unknown

If *Neisseria meningitidis* was isolated from BLOOD or CSF, was it resistant to SULFA? Yes No Not Tested

If *Neisseria meningitidis* was isolated from BLOOD or CSF, was it resistant to RIFAMPIN? Yes No Not Tested

If *Streptococcus pneumoniae* was isolated from CSF, was it resistant to PENICILLIN? Yes No Not Tested

REMARKS

Texas Department of Health, Infectious Disease Epidemiology and Surveillance Division Austin, Texas (512) 458-7676 IDEAS Form 4, 04/96

DOCUMENT USED IN : CC EPIDEMIOLOGY

Attachment H: Mandated Forms

EXPOSURE DATA

Complete this section for meningococcal (*Neisseria meningitidis*) infections only.

Did any member of the patient's household have a similar illness during the 60 days prior to onset? YES NO

Name: _____ DOB: _____ Relationship: _____ Date of Illness: _____

Total number of household contacts: _____ Number who were prophylaxed: _____ Date prophylaxed: _____

Did the patient attend/work at a day-care center/home during the 60 days prior to onset? YES NO

Name of center/home: _____ Address:_____ Date last attended: _____

Total classroom contacts: _____ Students _____ Staff Number Prophylaxed: _____ Students _____ Staff

Did any other child in this center have a similar infection during the 60 days prior to onset? YES NO
If yes list names, date of illness, and complete a Bacterial Meningitis form for each case:

_____ _____ _____

RECOMMENDATIONS

The following groups of individuals should receive chemoprophylaxis after exposure to meningococcal disease

- **All family contacts or household members who spend at least 8 hours a day with the case.**
- **Classroom contacts in the day-care center or day-care home attended by the case.**
- **Persons directly exposed to infectious oral secretions**
- **Index case(s) should receive prophylaxis prior to discharge**

It is important that antimicrobial chemoprophylaxis be administered as soon as possible, ideally within 24 hours. Chemoprophylaxis given more than 14 days after exposure is of limited value.

When prophylaxis is indicated, it should be administered to all eligible contacts at the same time to eliminate the organism from that population. Prophylaxis should begin within 24 hours of diagnosis or strong suspicion of case. Culturing of contacts is not recommended. Prophylaxis should not substitute for close observation of case contacts for symptoms.

Drugs and Dosage Recommendations for Meningococcal Chemoprophylaxis

Drug	Age Group	Dosage [1]	Duration
Sulfisoxazole [2]	Infants	500mg/day	2 days
	Children 1 -12 years	500mg q 12hours	2 days
	Persons >12 years	1 gram q 12 hours	2 days
Rifampin	Children < 1 month	5mg/kg q 12 hours	2 days
	Children ≥ 1 month	10mg/kg q 12 hours	2 days
	Adults [3]	600mg q 12 hours	2 days
Ciprofloxacin	Adults [3] > 18 years	500mg	Single dose
Ceftriazone	Children < 15 years	125 mg	Single IM Dose
	Adults	250mg	Single IM dose

1 - All doses are oral unless otherwise specified.
2 - Only given if organism is known to be sensitive.
3 - Pregnant women should not take rifampin or ciprofloxacin

Investigated by: _____ Date: _____

Agency: _____ Phone #: (_____) _____

Infectious Disease Control Unit, Texas Department of State Health Services
P.O. Box 149347, MC 1960
Austin, Texas 78714-149347

DOCUMENT USED IN : CC EPIDEMIOLOGY

Pertussis Case Track Record

FINAL STATUS:
☐ CONFIRMED ☐ PROBABLE
☐ RULED OUT/DROPPED

NBS PATIENT ID#: _____

Patient's Name: _____
Last First
Address: _____
City: _____ County: _____ Zip: _____
Region: _____ Phone:( ) _____
Parent/Guardian: _____
Physician: _____Phone:( ) _____
Physician's Address: _____
_____

Reported By: _____
Agency: _____
Phone:( )_____
Date: _____/_____/_____
Report Given to: _____
Organization: _____
Phone: ( ) _____
Date: _____/_____/_____

DEMOGRAPHICS:

DATE OF BIRTH: _____/_____/_____ *AGE:* _____ *SEX:* ☐ Male ☐ Female ☐ Unknown

RACE: ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Native American ☐ Unknown ☐ Other: _____

HISPANIC: ☐ Yes ☐ No ☐ Unknown

CLINICAL DATA:

☐ Cough - *Onset Date:* _____/_____/_____ *Final Cough Duration* (*total* # of days) _____
☐ Paroxysmal Cough - Onset Date: _____/_____/_____
☐ Inspiratory Whoop ☐ Vomiting after Paroxysm
☐ Apnea (Exclude Cyanotic Episode) ☐ Cyanosis after Paroxysm
☐ Pneumonia: Chest X-Ray ☐ + ☐ - ☐ Seizures (Focal or Generalized)
☐ Acute Encephalopathy ☐ Other: _____
Is patient still coughing at final interview? ☐ Yes ☐ No ***Date:*** ____/_____/____
☐ Hospitalized at: _____
Admitted: _____/_____/_____ Discharged: _____/_____/_____ # Days_____
Physician Diagnosis:_____

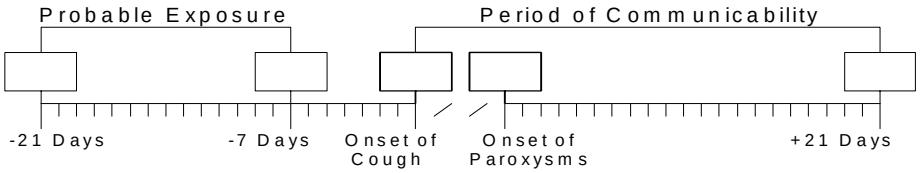
TREATMENT:

Were antibiotics given? ☐ Yes ☐ No
☐ Erythromycin: Date Started:_____/_____/_____for _____ Days
☐ Cotrimoxazole: Date Started:_____/____/_____for _____ Days
☐ Azithromycin: Date Started:_____/_____/_____for _____ Days
☐ Tetracycline: Date Started:_____/_____/_____for _____ Days
☐ Ampicillin: Date Started:_____/_____/_____for _____ Days
☐ Other:_____ Date Started:____/____/____for _____ Days
☐ Other:_____ Date Started:____/____/____for _____ Days

OUTCOME: ☐ Survived ☐ Died ☐ Unknown

If Deceased, Date of Death: ____/_____/_____ **Note:** A Pertussis Death Worksheet must also be submitted to DSHS.

INFECTION TIMELINE: Enter onset of cough. Count backwards and forwards to enter dates for probable exposure and communicable periods.



VACCINATION HISTORY:

VACCINATED: ☐ Yes ☐ No ☐ Unknown

☐ 1 DTP: ____/____/____ Type: ☐ DTP ☐ DTaP ☐ DTP-Hib ☐ DT Manufacturer: _____ Lot #:_____
☐ 2 DTP: ____/____/____ Type: ☐ DTP ☐ DTaP ☐ DTP-Hib ☐ DT Manufacturer: _____ Lot #:_____
☐ 3 DTP: ____/____/____ Type: ☐ DTP ☐ DTaP ☐ DTP-Hib ☐ DT Manufacturer: _____ Lot #:_____
☐ 4 DTP: ____/____/____ Type: ☐ DTP ☐ DTaP ☐ DTP-Hib ☐ DT Manufacturer: _____ Lot #:_____
☐ 5 DTP: ____/____/____ Type: ☐ DTP ☐ DTaP ☐ DTP-Hib ☐ DT Manufacturer: _____ Lot #:_____

If no, indicate reason: ☐ Religious exemption ☐ Medical Contraindication ☐ Evidence of immunity ☐ Previous Disease - Lab Confirmed
☐ Previous Disease - MD Diagnosed ☐ Under Age ☐ Parental Refusal ☐ Unknown ☐ Other: _____

Name: _____

Attachment H: Mandated Forms

LABORATORY DATA: *Was laboratory testing done?* ☐ Yes ☐ No ☐ Unknown

LABORATORY: ☐ DSHS ☐ Other: _____ Phone:( ) _____

☐ Culture: Date specimen collected: _____/_____/_____ Result: _____

☐ PCR: Date specimen collected: _____/_____/_____ Result: _____

☐ DFA: Date specimen collected: _____/_____/_____ Result: _____

☐ IgA ☐ IgG: Date of acute specimen: _____/_____/_____ Result: _____

Date of convalescent specimen: _____/_____/_____ Result: _____

Note: *A four-fold rise in titer level from acute specimen to convalescent sample may be considered positive serology for pertussis. Results from a single specimen are not accepted as laboratory confirmation of a suspected pertussis case.*

Results called to local investigator: ☐ Yes ☐ No ☐ Unknown

Person Contacted: _____ Date Called: _____/_____/_____ Initials: _____

SOURCE OF INFECTION: ☐ No exposure Identified ☐ Close contact with a known or suspected case.

Date of Contact	Name	Age	Address	Phone	Case No.
____/____/____	_____	____	_____	( )_____	_____

☐ Is case epidemiologically linked to a culture-confirmed case? ☐ Yes ☐ No ☐ Unknown

☐ Where did this case acquire pertussis?: ☐ Day-care ☐ School ☐ College ☐ Work ☐ Home ☐ Dr Office ☐ Hospital ER ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Military ☐ Jail ☐ Church ☐ International Travel ☐ Unknown ☐ Other: _____

Name(s) of Setting:_____

☐ Has any travel occurred within the exposure period? ☐ Yes ☐ No ☐ Unknown If yes, list location: _____

☐ Importation Class: ☐ Indigenous ☐ International ☐ Out-of-state ☐ Unknown If imported, from what country/state:_____

☐ Is case traceable within 2 generations to international import? ☐ Yes ☐ No ☐ Unknown

☐ Is case part of an outbreak?: ☐ Yes ☐ No ☐ Unknown If yes, list outbreak name: _____

Total number of contacts in any settings recommended antibiotics: _____

HOUSEHOLD CONTACTS: Were control activities initiated?: ☐ Yes ☐ No ☐ Unknown If no, explain: _____

Name	Relation to Case	Age	Vaccination HX	*Symptoms/Date of Onset	Type of Prophylaxis/Date Treated

***Investigations must be completed on all contacts with symptoms**

POSSIBLE SPREAD CONTACT:

Setting: ☐ No Spread ☐ Day-care ☐ School ☐ College ☐ Work ☐ Home ☐ Dr. Office ☐ Hospital ER ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Military ☐ Jail ☐ Church ☐ International Travel ☐ Unknown ☐ Other: _____

Name (s) of Settings: _____

Name	Relation to Case	Age	Vaccination HX	*Symptoms/Date of Onset	Type of Prophylaxis/Date Treated

***Investigations must be completed on all contacts with symptoms**

Investigator's Name: _____ Agency name: _____

Phone:( ) _____ Date Investigation Initiated: _____/_____/_____ Date Investigation Completed: ____/_____/____

COMMENTS:

DOCUMENT USED IN : CC EPIDEMIOLOGY

TEXAS Department of State Health Services

l Forms

VARICELLA (chickenpox) Reporting Form

Please use this form to report cases of varicella to your local office, Collin County Health Care Services: 972-548-4436

ONSET DATE	VACCINATED AGAINST VARICELLA? Yes No Number of Doses Received? 1 2 Date(s) Varicella Vaccine Administered: _____/_____/_____ , _____/_____/_____			
LAST NAME	FIRST	DOB	SEX	RACE
ADDRESS	CITY	ZIP CODE	HISPANIC? Yes No	

ONSET DATE	VACCINATED AGAINST VARICELLA? Yes No Number of Doses Received? 1 2 Date(s) Varicella Vaccine Administered: _____/_____/_____ , _____/_____/_____			
LAST NAME	FIRST	DOB	SEX	RACE
ADDRESS	CITY	ZIP CODE	HISPANIC? Yes No	

ONSET DATE	VACCINATED AGAINST VARICELLA? Yes No Number of Doses Received? 1 2 Date(s) Varicella Vaccine Administered: _____/_____/_____ , _____/_____/_____			
LAST NAME	FIRST	DOB	SEX	RACE
ADDRESS	CITY	ZIP CODE	HISPANIC? Yes No	

ONSET DATE	VACCINATED AGAINST VARICELLA? Yes No Number of Doses Received? 1 2 Date(s) Varicella Vaccine Administered: _____/_____/_____ , _____/_____/_____			
LAST NAME	FIRST	DOB	SEX	RACE
ADDRESS	CITY	ZIP CODE	HISPANIC? Yes No	

AGENCY REPORTED BY: _____ **PHONE:** _____

CITY: _____ **COUNTY:** _____

DATE REPORTED: _____

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
INFECTIOUS DISEASE CONTROL UNIT

STOCK NO. F11-11046
REVISED 08/2007

ANTHRAX VACCINE

WHAT YOU NEED TO KNOW

1 What is anthrax?

Anthrax is a serious disease that can affect both animals and humans. It is caused by bacteria called *Bacillus anthracis*. People can get anthrax from contact with infected animals, wool, meat, or hides. In its most common form, anthrax is a skin disease that causes skin ulcers and usually fever and fatigue. Up to 20% of these cases are fatal if untreated.

When *B. anthracis* is inhaled, as when used as a biological weapon, it is much more serious. The first symptoms may include a sore throat, mild fever and muscle aches. But within several days these symptoms are followed by severe breathing problems, shock, and often meningitis (inflammation of the brain and spinal cord covering). Once symptoms appear, this form of anthrax is almost always fatal, despite treatment with antibiotics.

2 What is anthrax vaccine?

Anthrax vaccine protects against anthrax disease. The U.S. vaccine does not contain actual *B. anthracis* cells and it does not cause anthrax disease. Anthrax vaccine was licensed in 1970.

Based on limited but convincing evidence, the vaccine protects against both cutaneous (skin) and inhalational anthrax.

3 Who should get anthrax vaccine and when?

People 18 to 65 years of age potentially exposed to large amounts of *B. anthracis* bacteria on the job, such as laboratory workers.

Military personnel who may be at risk of anthrax exposure from weapons.

The basic vaccine series consists of **6** doses.

- The first three doses are given at two-week intervals.
- Three additional doses are given, at 6, 12, and 18 months after the first dose.

Annual booster doses are needed for ongoing protection.

If a dose is not given at the scheduled time, the series does not have to be started over. Resume the series as soon as practical.

Anthrax vaccine may be given at the same time as other vaccines.

4 Some people should not get anthrax vaccine or should wait

Anyone who has had a serious allergic reaction to a previous dose of anthrax vaccine should not get another dose.

Anyone who has recovered from cutaneous (skin) anthrax should not get the vaccine.

Pregnant women should not be routinely vaccinated with anthrax vaccine. This is merely a precaution. There is no evidence that the vaccine is harmful to either a pregnant woman or her unborn baby. Vaccination *may* be recommended for pregnant women who have been exposed, or are likely to be exposed, to anthrax.

There is no reason to delay childbearing after either the man or the woman gets anthrax vaccine.

Vaccines, including anthrax vaccine, are safe to give to breast-feeding women.

5 What are the risks from anthrax vaccine?

Getting anthrax disease is much more dangerous than any risk from the vaccine.

Like any medicine, a vaccine is capable of causing serious problems, such as severe allergic reactions. The risk of anthrax vaccine causing serious harm, or death, is extremely small.

Mild Problems

- Soreness, redness, or itching where the shot was given (about 1 out of 10 men, about 1 out of 6 women)
- A lump where the shot was given (about 1 person out of 2)
- Muscle aches or joint aches (about 1 person out of 5)
- Headaches (about 1 person out of 5)
- Fatigue (about 1 out of 15 men, about 1 out of 6 women)
- Chills or fever (about 1 person out of 20)
- Nausea (about 1 person out of 20).

Moderate Problems

- Large areas of redness where the shot was given (up to l person out of 20).

Severe Problems

- Serious allergic reaction (very rare - less than once in 100,000 doses).

As with any vaccine, other severe problems have been reported. But these events appear to occur no more often among anthrax vaccine recipients than among unvaccinated people.

There is no evidence that anthrax vaccine causes sterility, birth defects, or long-term health problems.

Independent civilian committees have not found anthrax vaccination to be a factor in unexplained illnesses among Gulf War veterans.

6 What if there is a moderate or severe reaction?

What should I look for?

Any unusual condition, such as a severe allergic reaction or a high fever. If a severe allergic reaction occurred, it would happen within a few minutes to an hour after the shot. Signs of a serious allergic reaction can include difficulty breathing, weakness, hoarseness or wheezing, a fast heart beat, hives, dizziness, paleness, or swelling of the throat.

What should I do?

- Call a doctor, or get the person to a doctor right away.
- Tell your doctor what happened, the date and time it happened, and when the vaccination was given.
- Ask your health care provider to file a Vaccine Adverse Event Reporting System (VAERS) form if you have *any* reaction to the vaccine. Or call VAERS yourself at **1-800-822-7967,** or visit their website at **www.vaers.org.**

7 How can I learn more?

- Ask your doctor or other health care provider. They can give you the vaccine package insert or suggest other sources of information.

- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit the CDC's website at **www.cdc.gov/ncidod/dbmd/diseaseinfo/anthrax_g.htm**

- Contact the U.S Department of Defense (DoD):
  - Call **1-877-438-8222**
  - Visit the DoD website at **www.anthrax.osd.mil**

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention
National Immunization Program

DOCUMENT USED IN :
CC IMMUNIZATIONS CLINIC

Attachment H Mandated

DIPHTHERIA TETANUS & PERTUSSIS VACCINES

WHAT YOU NEED TO KNOW

1 Why get vaccinated?

Diphtheria, tetanus, and pertussis are serious diseases caused by bacteria. Diphtheria and pertussis are spread from person to person. Tetanus enters the body through cuts or wounds.

DIPHTHERIA causes a thick covering in the back of the throat.

- It can lead to breathing problems, paralysis, heart failure, and even death.

TETANUS (Lockjaw) causes painful tightening of the muscles, usually all over the body.

- It can lead to "locking" of the jaw so the victim cannot open his mouth or swallow. Tetanus leads to death in up to 2 out of 10 cases.

PERTUSSIS (Whooping Cough) causes coughing spells so bad that it is hard for infants to eat, drink, or breathe. These spells can last for weeks.

- It can lead to pneumonia, seizures (jerking and staring spells), brain damage, and death.

Diphtheria, tetanus, and pertussis vaccine (DTaP) can help prevent these diseases. Most children who are vaccinated with DTaP will be protected throughout childhood. Many more children would get these diseases if we stopped vaccinating.

DTaP is a safer version of an older vaccine called DTP. DTP is no longer used in the United States.

2 Who should get DTaP vaccine and when?

Children should get 5 doses of DTaP vaccine, one dose at each of the following ages:

✓ 2 months ✓ 4 months ✓ 6 months
✓15-18 months ✓ 4-6 years

DTaP may be given at the same time as other vaccines.

3 Some children should not get DTaP vaccine or should wait

- Children with minor illnesses, such as a cold, may be vaccinated. But children who are moderately or severely ill should usually wait until they recover before getting DTaP vaccine.
- Any child who had a life-threatening allergic reaction after a dose of DTaP should not get another dose.
- Any child who suffered a brain or nervous system disease within 7 days after a dose of DTaP should not get another dose.
- Talk with your doctor if your child:
  - had a seizure or collapsed after a dose of DTaP,
  - cried non-stop for 3 hours or more after a dose of DTaP,
  - had a fever over 105ºF after a dose of DTaP.

Ask your health care provider for more information. Some of these children should not get another dose of pertussis vaccine, but may get a vaccine without pertussis, called **DT**.

4 Older children and adults

DTaP is not licensed for adolescents, adults, or children 7 years of age and older.

But older people still need protection. A vaccine called **Tdap** is similar to DTaP. A single dose of Tdap is recommended for people 11 through 64 years of age. Another vaccine, called **Td**, protects against tetanus and diphtheria, but not pertussis. It is recommended every 10 years. There are separate Vaccine Information Statements for these vaccines.

Diphtheria/Tetanus/Pertussis	5/17/2007

5 What are the risks from DTaP vaccine?

Getting diphtheria, tetanus, or pertussis disease is much riskier than getting DTaP vaccine.

However, a vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of DTaP vaccine causing serious harm, or death, is extremely small.

Mild Problems (Common)

- Fever (up to about 1 child in 4)
- Redness or swelling where the shot was given (up to about 1 child in 4)
- Soreness or tenderness where the shot was given (up to about 1 child in 4)

These problems occur more often after the 4th and 5th doses of the DTaP series than after earlier doses. Sometimes the 4th or 5th dose of DTaP vaccine is followed by swelling of the entire arm or leg in which the shot was given, lasting 1-7 days (up to about 1 child in 30).

Other mild problems include:

- Fussiness (up to about 1 child in 3)
- Tiredness or poor appetite (up to about 1 child in 10)
- Vomiting (up to about 1 child in 50)

These problems generally occur 1-3 days after the shot.

Moderate Problems (Uncommon)

- Seizure (jerking or staring) (about 1 child out of 14,000)
- Non-stop crying, for 3 hours or more (up to about 1 child out of 1,000)
- High fever, over 105ºF (about 1 child out of 16,000)

Severe Problems (Very Rare)

- Serious allergic reaction (less than 1 out of a million doses)
- Several other severe problems have been reported after DTaP vaccine. These include:
  - Long-term seizures, coma, or lowered consciousness
  - Permanent brain damage.

  These are so rare it is hard to tell if they are caused by the vaccine.

Controlling fever is especially important for children who have had seizures, for any reason. It is also important if another family member has had seizures. You can reduce fever and pain by giving your child an *aspirin-free* pain reliever when the shot is given, and for the next 24 hours, following the package instructions.

6 What if there is a moderate or severe reaction?

What should I look for?

Any unusual conditions, such as a serious allergic reaction, high fever or unusual behavior. Serious allergic reactions are extremely rare with any vaccine. If one were to occur, it would most likely be within a few minutes to a few hours after the shot. Signs can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness. If a high fever or seizure were to occur, it would usually be within a week after the shot.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.
  VAERS does not provide medical advice

7 The National Vaccine Injury Compensation Program

In the rare event that you or your child has a serious reaction to a vaccine, a federal program has been created to help pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call **1-800-338-2382** or visit the program's website at **www.hrsa.gov/vaccinecompensation.**

8 How can I learn more?

- Ask your health care provider. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department's immunization program.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit the National Immunization Program's website at **www.cdc.gov/nip**

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention

Vaccine Information Statement
DTaP (5/17/07) 42 U.S.C. § 300aa-26

TEXAS Department of State Health Services

Texas Department of State Health Services

Addendum to Diphtheria, Tetanus, and Pertussis Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given:
- ☐ DTP (Diphtheria, Tetanus, and Pertussis Vaccine)
- ☐ DT (Diphtheria and Tetanus Vaccine)
- ☐ DTaP (Diphtheria, Tetanus, and acellular Pertussis Vaccine)

Information about person to receive vaccine (Please print)

Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one) M F

Address: Street	City	County	State	Zip
			TX	

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

x _____ Date _____

_____ Date _____
Witness

For Clinic/Office Use

Clinic/Office Address:

Date Vaccine Administered:

Vaccine Manufacturer:

Vaccine Lot Number:

Site of Administration:

Signature of Vaccine Administrator:

Title of Vaccine Administrator:

PRIVACY NOTIFICATION - With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

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Instructions: File this consent statement in the patient's chart.

Texas Department of State Health Services
C-91 (05/07)

CDC VIS Revision 05/17/2007

Texas Department of State Health Services

Department of State Health Services

Addendum to 2009 H1N1 Inactivated Influenza Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

*STATEMENT: I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the party who accepts assignment.

Vaccine to be given: ☐ Inactivated 2009 H1N1 Influenza Vaccine

Provider Identification No.: _____ Medicare Health Insurance Claim No.: _____

Information about person to receive vaccine (Please print)				
Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one) M F
Mother's First Name (if client is less than 18 years of age)		Mother's Maiden Name (if client is less than 18 years of age)		
Address: Street	City	County	State TX	Zip

Age Group Category: (Check only one please) ☐ **6-23 months** ☐ **24-59 months** ☐ **5-18 years** ☐ **19-24 years** ☐ **25-49 years** ☐ **50-64 years** ☐ **65+ years**

_____ Date: _____
Signature of person to receive vaccine or person authorized to make the request (parent or guardian) (mm/dd/yy)

_____ Date: _____
Witness (mm/dd/yy)

For Clinic/Office Use
Clinic/Office Address:
Date Vaccine Administered:
Vaccine Manufacturer:
Vaccine Lot Number:
Site of Administration: ☐ Imm / where?_____
Signature of Vaccine Administrator:
Title of Vaccine Administrator:
Dose Number: (Please check one) ☐ **1st** ☐ **2nd** ☐ **Unknown**

Consent for Retention of Disaster-Related Information and Release of Information to Authorized Entities

I understand that, by granting the consent below, I am authorizing retention of my (or my child's) disaster-related information by DSHS beyond the 5 year retention period. I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac"). Once in ImmTrac, my (or my child's) disaster-related information may by law be accessed by:

- a state agency, for the purpose of aiding and coordinating communicable disease prevention and control efforts, and/or
- a physician or other health care provider legally authorized to administer immunizations, antivirals, and other medications, for treating the client as a patient;

I understand that I may withdraw this consent to retain information in the ImmTrac Registry beyond the 5 year retention period and my consent to release information from the Registry, at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent to retain my disaster-related information (or my child's information if under age 18) in the Texas immunization registry beyond the 5 year retention period.

Client (or parent, legal guardian or managing conservator): _____
Printed Name

_____ _____
Date (mm/dd/yy) **Signature**

PRIVACY NOTIFICATION - With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

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Instructions: File this consent statement in the patient's chart.

Texas Department of State Health Services
C-84 (10/09)

CDC 2009 H1N1 Inactivated Influenza Vaccine VIS Revision 10/02/09

Texas Department of State Health Services

TEXAS Department of State Health Services

Addendum to 2009 H1N1 Live, Attenuated Influenza Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

*STATEMENT: I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the party who accepts assignment.

Vaccine to be given: ☐ 2009 H1N1 LAIV Vaccine

Provider Identification No.: _____ Medicare Health Insurance Claim No.: _____

Information about person to receive vaccine (Please print)

Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one) M F

Mother's First Name (if client is less than 18 years of age)	Mother's Maiden Name (if client is less than 18 years of age)

Address: Street	City	County	State	Zip
			TX	

Age Group Category: (Check only one please) ☐ **6-23 months** ☐ **24-59 months** ☐ **5-18 years** ☐ **19-24 years** ☐ **25-49 years** ☐ **50-64 years** ☐ **65+ years**

_____ Date: _____
Signature of person to receive vaccine or person authorized to make the request (parent or guardian) (mm/dd/yy)

_____ Date: _____
Witness (mm/dd/yy)

For Clinic/Office Use
Clinic/Office Address:

Date Vaccine Administered:

Vaccine Manufacturer:

Vaccine Lot Number:

Site of Administration:
☐ Nasal _____

Signature of Vaccine Administrator:

Title of Vaccine Administrator:

Dose Number: (Please check one)
☐ **1st** ☐ **2nd** ☐ **Unknown**

Consent for Retention of Disaster-Related Information and Release of Information to Authorized Entities

I understand that, by granting the consent below, I am authorizing retention of my (or my child's) disaster-related information by DSHS beyond the 5 year retention period. I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac"). Once in ImmTrac, my (or my child's) disaster-related information may by law be accessed by:

- a state agency, for the purpose of aiding and coordinating communicable disease prevention and control efforts, and/or
- a physician or other health care provider legally authorized to administer immunizations, antivirals, and other medications, for treating the client as a patient;

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By my signature below, I GRANT consent to retain my disaster-related information (or my child's information if under age 18) in the Texas immunization registry beyond the 5 year retention period.

Client (or parent, legal guardian or managing conservator): _____
Printed Name

_____ _____
Date (mm/dd/yy) **Signature**

PRIVACY NOTIFICATION - With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

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Instructions: File this consent statement in the patient's chart.

HEPATITIS A VACCINE

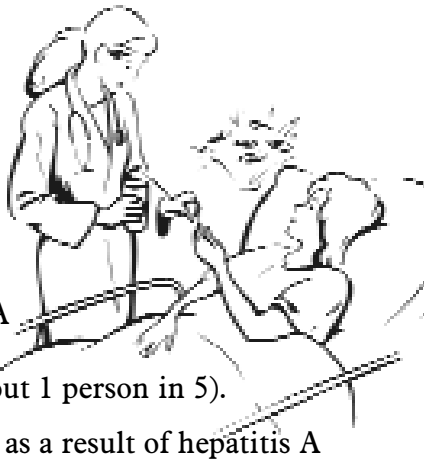
WHAT YOU NEED TO KNOW

1 What is hepatitis A?

Hepatitis A is a serious liver disease caused by the hepatitis A virus (HAV). HAV is found in the stool of persons with hepatitis A. It is usually spread by close personal contact and sometimes by eating food or drinking water containing HAV.

Hepatitis A can cause:

- mild "flu-like" illness
- jaundice (yellow skin or eyes)
- severe stomach pains and diarrhea



People with hepatitis A often have to be hospitalized (up to about 1 person in 5).

Sometimes, people die as a result of hepatitis A (about 3-5 deaths per 1,000 cases).

A person who has hepatitis A can easily pass the disease to others within the same household.

Hepatitis A vaccine can prevent hepatitis A.

2 Who should get hepatitis A vaccine and when?

WHO?

Some people should be routinely vaccinated with hepatitis A vaccine:

- All children 1 year (12 through 23 months) of age.
- Persons 1 year of age and older traveling to or working in countries with high or intermediate prevalence of hepatitis A, such as those located in Central or South America, Mexico, Asia (except Japan), Africa, and eastern Europe. For more information see **www.cdc.gov/travel**.
- Children and adolescents through 18 years of age who live in states or communities where routine vaccination has been implemented because of high disease incidence.
- Men who have sex with men.
- Persons who use street drugs.
- Persons with chronic liver disease.
- Persons who are treated with clotting factor concentrates.
- Persons who work with HAV-infected primates or who work with HAV in research laboratories.

Other people might get hepatitis A vaccine in special situations:

- Hepatitis A vaccine might be recommended for children or adolescents in communities where outbreaks of hepatitis A are occurring.

Hepatitis A vaccine is not licensed for children younger than 1 year of age.

WHEN?

For children, the first dose should be given at 12-23 months of age. Children who are not vaccinated by 2 years of age can be vaccinated at later visits.

For travelers, the vaccine series should be started at least one month before traveling to provide the best protection.

> Persons who get the vaccine less than one month before traveling can also get a shot called immune globulin (IG). IG gives immediate, temporary protection.

For others, the hepatitis A vaccine series may be started whenever a person is at risk of infection.

Two doses of the vaccine are needed for lasting protection. These doses should be given at least 6 months apart.

Hepatitis A vaccine may be given at the same time as other vaccines.

Hepatitis A	3/21/06

3 Some people should not get hepatitis A vaccine or should wait

- Anyone who has ever had a severe (life-threatening) **allergic reaction to a previous dose** of hepatitis A vaccine should not get another dose.
- Anyone who has a severe (life threatening) **allergy to any vaccine component** should not get the vaccine. Tell your doctor if you have any severe allergies. All hepatitis A vaccines contain alum and some hepatitis A vaccines contain 2-phenoxyethanol.
- Anyone who is **moderately or severely ill** at the time the shot is scheduled should probably wait until they recover. Ask your doctor or nurse. People with a **mild illness** can usually get the vaccine.
- Tell your doctor if you are **pregnant**. The safety of hepatitis A vaccine for pregnant women has not been determined. But there is no evidence that it is harmful to either pregnant women or their unborn babies. The risk, if any, is thought to be very low.

4 What are the risks from hepatitis A vaccine?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of hepatitis A vaccine causing serious harm, or death, is extremely small.

Getting hepatitis A vaccine is much safer than getting the disease.

Mild problems

- soreness where the shot was given *(about 1 out of 2 adults, and up to 1 out of 6 children)*
- headache *(about 1 out of 6 adults and 1 out of 25 children)*
- loss of appetite *(about 1 out of 12 children)*
- tiredness *(about 1 out of 14 adults)*

If these problems occur, they usually last 1 or 2 days.

Severe problems

- serious allergic reaction, within a few minutes to a few hours of the shot *(very rare)*

5 What if there is a moderate or severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

  VAERS does not provide medical advice.

6 The National Vaccine Injury Compensation Program

In the event that you or your child has a serious reaction to a vaccine, a federal program has been created to help pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call 1-800-338-2382 or visit their website at www.hrsa.gov/vaccinecompensation.

7 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit CDC websites at: **www.cdc.gov/hepatitis** or **www.cdc.gov/nip**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL IMMUNIZATION PROGRAM

DOCUMENT USED IN : CC IMMUNIZATIONS CLINIC

Attachment H: Mandated Forms

TEXAS Department of State Health Services

Texas Department of State Health Services

Addendum to Hepatitis A Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: ☐ Hepatitis A Vaccine

Information about person to receive vaccine (Please print)				
Name: Last First Middle Initial			Birthdate (mm/dd/yy)	Sex (circle one) M F
Address: Street	City	County	State TX	Zip

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

x _____ Date _____

_____ Date _____
Witness

For Clinic/Office Use
Clinic/Office Address:
Date Vaccine Administered:
Vaccine Manufacturer:
Vaccine Lot Number:
Site of Administration:
Signature of Vaccine Administrator:
Title of Vaccine Administrator:

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Texas Department of State Health Services
EC-95 (03/06)

CDC VIS Revision 03/21/06

HEPATITIS B VACCINE

WHAT YOU NEED TO KNOW

1 What is hepatitis B?

Hepatitis B is a serious disease that affects the liver. It is caused by the hepatitis B virus (HBV). HBV can cause:

Acute (short-term) illness. This can lead to:
- loss of appetite
- diarrhea and vomiting
- tiredness
- jaundice (yellow skin or eyes)
- pain in muscles, joints, and stomach

Acute illness is more common among adults. Children who become infected usually do not have acute illness.

Chronic (long-term) infection. Some people go on to develop chronic HBV infection. This can be very serious, and often leads to:
- liver damage (cirrhosis)
- liver cancer
- death

Chronic infection is more common among infants and children than among adults. People who are infected can spread HBV to others, even if they don't appear sick.

- In 2005, about 51,000 people became infected with hepatitis B.
- About 1.25 million people in the United States have chronic HBV infection.
- Each year about 3,000 to 5,000 people die from cirrhosis or liver cancer caused by HBV.

Hepatitis B virus is spread through contact with the blood or other body fluids of an infected person. A person can become infected by:
- contact with a mother's blood and body fluids at the time of birth;
- contact with blood and body fluids through breaks in the skin such as bites, cuts, or sores;
- contact with objects that could have blood or body fluids on them such as toothbrushes or razors;
- having unprotected sex with an infected person;
- sharing needles when injecting drugs;
- being stuck with a used needle on the job.

2 Hepatitis B vaccine: Why get vaccinated?

Hepatitis B vaccine can prevent hepatitis B, and the serious consequences of HBV infection, including liver cancer and cirrhosis.

Routine hepatitis B vaccination of U.S. children began in 1991. Since then, the reported incidence of acute hepatitis B among children and adolescents has dropped by more than 95% – and by 75% in all age groups.

Hepatitis B vaccine is made from a part of the hepatitis B virus. It cannot cause HBV infection.

Hepatitis B vaccine is usually given as **a series of 3 or 4 shots**. This vaccine series gives long-term protection from HBV infection, possibly lifelong.

3 Who should get hepatitis B vaccine and when?

Children and Adolescents

- All children should get their first dose of hepatitis B vaccine **at birth** and should have completed the vaccine series by 6-18 months of age.
- Children and adolescents through 18 years of age who did not get the vaccine when they were younger should also be vaccinated.

Adults

- All unvaccinated adults **at risk for HBV infection** should be vaccinated. This includes:
  - sex partners of people infected with HBV,
  - men who have sex with men,
  - people who inject street drugs,
  - people with more than one sex partner,
  - people with chronic liver or kidney disease,
  - people with jobs that expose them to human blood,
  - household contacts of people infected with HBV,
  - residents and staff in institutions for the developmentally disabled,
  - kidney dialysis patients,

- people who travel to countries where hepatitis B is common,
- people with HIV infection.

- Anyone else who wants to be protected from HBV infection may be vaccinated.

4 Who should NOT get hepatitis B vaccine?

- Anyone with a life-threatening allergy to **baker's yeast**, or to **any other component of the vaccine,** should not get hepatitis B vaccine. Tell your provider if you have any severe allergies.
- Anyone who has had a life-threatening allergic reaction to a **previous dose of hepatitis B vaccine** should not get another dose.
- Anyone who is **moderately or severely ill** when a dose of vaccine is scheduled should probably wait until they recover before getting the vaccine.

Your provider can give you more information about these precautions.

Pregnant women who need protection from HBV infection may be vaccinated.

5 Hepatitis B vaccine risks

Hepatitis B is a very safe vaccine. Most people do not have any problems with it.

The following **mild problems** have been reported:

- Soreness where the shot was given (up to about 1 person in 4).
- Temperature of 99.9°F or higher (up to about 1 person in 15).

Severe problems are extremely rare. Severe allergic reactions are believed to occur about once in 1.1 million doses.

A vaccine, like any medicine, ***could*** cause a serious reaction. But the risk of a vaccine causing serious harm, or death, is extremely small. More than 100 million people have gotten hepatitis B vaccine in the United States.

6 What if there is a moderate or severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

  VAERS does not provide medical advice.

7 The National Vaccine Injury Compensation Program

In the event that you or your child has a serious reaction to a vaccine, a federal program has been created to help pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call 1-800-338-2382 or visit their website at **www.hrsa.gov/vaccinecompensation**.

8 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit CDC websites at:
    www.cdc.gov/ncidod/diseases/hepatitis
    www.cdc.gov/vaccines
    www.cdc.gov/travel

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

Vaccine Information Statement (Interim)
Hepatitis B (7/18/07) 42 U.S.C. § 300aa-26

Texas Department of State Health Services

Addendum to Hepatitis B Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: ☐ Hepatitis B Vaccine

Information about person to receive vaccine (Please print)

Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one) M F
Address: Street	City	County	State TX	Zip

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

x _____ Date _____

_____ Date _____
Witness

For Clinic/Office Use

Clinic/Office Address:

Date Vaccine Administered:

Vaccine Manufacturer:

Vaccine Lot Number:

Site of Administration:

Signature of Vaccine Administrator:

Title of Vaccine Administrator:

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Texas Department of State Health Services
EC-106 (07/07)

CDC VIS Interim Revision 07/18/07

Haemophilus Influenzae Type b (Hib) Vaccine

WHAT YOU NEED TO KNOW

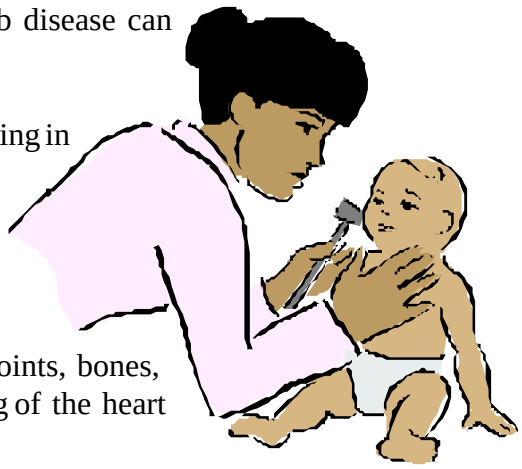
1 What is Hib disease?

***Haemophilus influenzae* type b (Hib) disease is a serious disease caused by a bacteria.** It usually strikes children under 5 years old.

Your child can get Hib disease by being around other children or adults who may have the bacteria and not know it. The germs spread from person to person. If the germs stay in the child's nose and throat, the child probably will not get sick. But sometimes the germs spread into the lungs or the bloodstream, and then Hib can cause serious problems.

Before Hib vaccine, Hib disease was the leading cause of bacterial meningitis among children under 5 years old in the United States. Meningitis is an infection of the brain and spinal cord coverings, which can lead to lasting brain damage and deafness. Hib disease can also cause:

- pneumonia
- severe swelling in the throat, making it hard to breathe
- infections of the blood, joints, bones, and covering of the heart
- death



Before Hib vaccine, about 20,000 children in the United States under 5 years old got severe Hib disease each year and nearly 1,000 people died.

Hib vaccine can prevent Hib disease.
Many more children would get Hib disease if we stopped vaccinating.

2 Who should get Hib vaccine and when?

Children should get Hib vaccine at:

- ✓ 2 months of age
- ✓ 4 months of age
- ✓ 6 months of age*
- ✓ 12-15 months of age

* Depending on what brand of Hib vaccine is used, your child might not need the dose at 6 months of age. Your doctor or nurse will tell you if this dose is needed.

If you miss a dose or get behind schedule, get the next dose as soon as you can. There is no need to start over.

Hib vaccine may be given at the same time as other vaccines.

Older Children and Adults

Children over 5 years old usually do not need Hib vaccine. But some older children or adults with special health conditions should get it. These conditions include sickle cell disease, HIV/AIDS, removal of the spleen, bone marrow transplant, or cancer treatment with drugs. Ask your doctor or nurse for details.

3 Some people should not get Hib vaccine or should wait

- People who have ever had a life-threatening allergic reaction to a previous dose of Hib vaccine should not get another dose.
- Children less than 6 weeks of age should not get Hib vaccine.
- People who are moderately or severely ill at the time the shot is scheduled should usually wait until they recover before getting Hib vaccine.

Ask your doctor or nurse for more information.

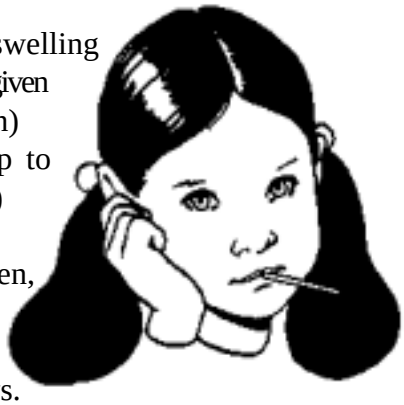
4 What are the risks from Hib vaccine?

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of Hib vaccine causing serious harm or death is extremely small.

Most people who get Hib vaccine do not have any problems with it.

Mild Problems

- Redness, warmth, or swelling where the shot was given (up to 1/4 of children)
- Fever over 101ºF (up to 1 out of 20 children)



If these problems happen, they usually start within a day of vaccination. They may last 2-3 days.

5 What if there is a moderate or severe reaction?

What should I look for?

Any unusual condition, such as a serious allergic reaction, high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat, or dizziness within a few minutes to a few hours after the shot.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

Or you can file this report through the VAERS web site at www.vaers.org, or by calling 1-800-822-7967.

VAERS does not provide medical advice

6 The National Vaccine Injury Compensation Program

In the rare event that you or your child has a serious reaction to a vaccine, a federal program has been created to help you pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call **1-800-338-2382** or visit the program's website at **www.hrsa.gov/osp/vicp**

7 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department's immunization program.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit the National Immunization Program's website at **www.cdc.gov/nip**

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention
National Immunization Program

Vaccine Information Statement
Hib (12/16/98) 42 U.S.C. § 300aa-26

DOCUMENT USED IN : CC IMMUNIZATIONS CLINIC

Attachment H: Mandated Forms

TEXAS Department of State Health Services

Texas Department of State Health Services

Addendum to *Haemophilus influenzae* type b (Hib) Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease, the vaccine, and how the vaccine is given.
6. I know that the person named below will have a vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: ☐ *Haemophilus influenzae* type b

Information about person to receive vaccine (Please print)				
Name: Last First Middle Initial			Birthdate (mm/dd/yy)	Sex (circle one) M F
Address: Street	City	County	State TX	Zip
Signature of person to receive vaccine or person authorized to make the request (parent or guardian): x _____ Date _____				
_____ Date _____ Witness				

For Clinic/Office Use
Clinic/Office Address:
Date Vaccine Administered:
Vaccine Manufacturer:
Vaccine Lot Number:
Site of Injection:
Signature of Vaccine Administrator:
Title of Vaccine Administrator:

PRIVACY NOTIFICATION - With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA Privacy Notice.

Notice: Alterations or changes to this publication is prohibited without the express written consent of the Texas Department of State Health Services, Immunization Branch.

Instructions: File this consent statement in the patient's chart.

Texas Department of State Health Services
EC-108 (01/06)

CDC VIS Revision 12/16/98

DOCUMENT USED IN : CC IMMUNIZATIONS CLINIC

Attachment B Mandated Forms

HPV (HUMAN PAPILLOMAVIRUS) VACCINE

WHAT YOU NEED TO KNOW

1 What is HPV?

Genital human papillomavirus (HPV) is the most common sexually transmitted virus in the United States.

There are about 40 types of HPV. About 20 million people in the U.S. are infected, and about 6.2 million more get infected each year. HPV is spread through sexual contact.

Most HPV infections don't cause any symptoms, and go away on their own. But HPV is important mainly because it can cause **cervical cancer** in women. Every year in the U.S. about 10,000 women get cervical cancer and 3,700 die from it. It is the 2nd leading cause of cancer deaths among women around the world.

HPV is also associated with several less common types of cancer in both men and women. It can also cause genital warts and warts in the upper respiratory tract.

More than 50% of sexually active men and women are infected with HPV at sometime in their lives.

There is no treatment for HPV infection, but the conditions it causes can be treated.

2 HPV Vaccine - Why get vaccinated?

HPV vaccine is an inactivated (not live) vaccine which protects against 4 major types of HPV.

These include 2 types that cause about 70% of cervical cancer and 2 types that cause about 90% of genital warts. ***HPV vaccine can prevent most genital warts and most cases of cervical cancer.***

Protection from HPV vaccine is expected to be long-lasting. But vaccinated women still need cervical cancer screening because the vaccine does not protect against all HPV types that cause cervical cancer.

3 Who should get HPV vaccine and when?

Routine Vaccination

- HPV vaccine is routinely recommended for girls **11-12 years of age**. Doctors may give it to girls as young as 9 years.

  Why is HPV vaccine given to girls at this age? It is important for girls to get HPV vaccine **before** their first sexual contact – because they have not been exposed to HPV. For these girls, the vaccine can prevent almost 100% of disease caused by the 4 types of HPV targeted by the vaccine.

  However, if a girl or woman is already infected with a type of HPV, the vaccine will not prevent disease from that type.

Catch-Up Vaccination

- The vaccine is also recommended for girls and women **13-26 years of age** who did not receive it when they were younger.

HPV vaccine is given as a 3-dose series:

1st Dose:	Now
2nd Dose:	2 months after Dose 1
3rd Dose:	6 months after Dose 1

Additional (booster) doses are not recommended.

HPV vaccine may be given at the same time as other vaccines.

4 Some girls or women should not get HPV vaccine or should wait

- Anyone who has ever had a life-threatening **allergic reaction** to **yeast**, to **any other component of HPV vaccine**, or to a **previous dose of HPV vaccine** should not get the vaccine. Tell your doctor if the person getting the vaccine has any severe allergies.

- **Pregnant women** should not get the vaccine. The vaccine appears to be safe for both the mother and the unborn baby, but it is still being studied. Receiving HPV vaccine when pregnant is **not** a reason to consider terminating the pregnancy. Women who are breast feeding may safely get the vaccine.

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> Any woman who learns that she was pregnant when she got HPV vaccine is encouraged to call the **HPV vaccine in pregnancy registry** at 800-986-8999.
>
> Information from this registry will help us learn how pregnant women respond to the vaccine.

- People who are mildly ill when the shot is scheduled can still get HPV vaccine. People with **moderate or severe illnesses** should wait until they recover.

5 What are the risks from HPV vaccine?

HPV vaccine does not appear to cause any serious side effects.

However, a vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of **any** vaccine causing serious harm, or death, is extremely small.

Several **mild problems** may occur with HPV vaccine:

- Pain at the injection site (about 8 people in 10)
- Redness or swelling at the injection site (about 1 person in 4)
- Mild fever (100°F) (about 1 person in 10)
- Itching at the injection site (about 1 person in 30)
- Moderate fever (102°F) (about 1 person in 65)

These symptoms do not last long and go away on their own.

Life-threatening allergic reactions from vaccines are very rare. If they do occur, it would be within a few minutes to a few hours after the vaccination.

Like all vaccines, HPV vaccine will continue to be monitored for unusual or severe problems.

6 What if there is a severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS website at www.vaers.hhs.gov, or by calling 1-800-822-7967.

  VAERS does not provide medical advice.

7 How can I learn more?

- Ask your doctor or nurse. They can show you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit CDC's website at **www.cdc.gov/vaccines.**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR IMMUNIZATION AND RESPIRATORY DISEASES

DOCUMENT USED IN : CC IMMUNIZATIONS CLINIC

Attachment H: Mandated Forms

Texas Department of State Health Services

Addendum to HPV (Human Papillomavirus) Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: ☐ HPV

Information about person to receive vaccine (Please print)

Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one) M F
Address: Street	City	County	State TX	Zip

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

x _____ Date _____

_____ Date _____
Witness

For Clinic/Office Use

Clinic/Office Address:

Date Vaccine Administered:

Vaccine Manufacturer:

Vaccine Lot Number:

Site of Administration:

Signature of Vaccine Administrator:

Title of Vaccine Administrator:

PRIVACY NOTIFICATION - With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA Privacy Notice.

Notice: Alterations or changes to this publication is prohibited without the express written consent of the Texas Department of State Health Services, Immunization Branch.

Instructions: File this consent statement in the patient's chart.

Texas Department of State Health Services
EC-111 (02/07)

CDC VIS Interim Revision 02/02/07

DOCUMENT USED IN : CC IMMUNIZATIONS CLINIC

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
CONSENT FORM

ImmTrac
Texas Immunization Registry

(Please print clearly)

For Clinic/Office Use

Child's Last Name

Child's First Name **Child's Middle Name**

/ / ***Children under 18 years only.***

Child's Date of Birth

Child's Gender: ☐ **Male** ☐ **Female**

Child's Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and
Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac"). Once in ImmTrac, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian or managing conservator: _____
Printed Name

_____ _____
Date **Signature**

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Questions? (800) 252-9152 • (512) 458-7284 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. C-7
Revised 07/22/08

TEXAS Department of State Health Services

PROVIDERS REGISTERED WITH ImmTrac *– Please enter client information in ImmTrac and* ***affirm*** *that consent has been granted.* ***DO NOT fax to ImmTrac. Retain this form in your client's record.***

INACTIVATED INFLUENZA VACCINE

WHAT YOU NEED TO KNOW 2007-08

1 Why get vaccinated?

Influenza ("flu") is a contagious disease.

It is caused by the influenza virus, which spreads from infected persons to the nose or throat of others.

Other illnesses can have the same symptoms and are often mistaken for influenza. But only an illness caused by the influenza virus is really influenza.

Anyone can get influenza, but rates of infection are highest among children. For most people, it lasts only a few days. It can cause:

· fever · sore throat · chills · fatigue
· cough · headache · muscle aches

Some people get much sicker. Influenza can lead to pneumonia and can be dangerous for people with heart or breathing conditions. It can cause high fever and seizures in children. On average, 226,000 people are hospitalized every year because of influenza and 36,000 die – mostly elderly.

Influenza vaccine can prevent influenza.

2 Inactivated Influenza vaccine

There are two types of influenza vaccine:

Inactivated (killed) vaccine, or the "flu shot" is given by injection into the muscle.

Live, attenuated (weakened) influenza vaccine, called LAIV, is sprayed into the nostrils. *This vaccine is described in a separate Vaccine Information Statement.*

For most people influenza vaccine prevents serious influenza-related illness. But it will *not* prevent "influenza-like" illnesses caused by other viruses.

Influenza viruses are always changing. Because of this, influenza vaccines are updated every year, and an annual vaccination is recommended. Protection lasts up to a year.

It takes up to 2 weeks for protection to develop after the vaccination.

Some inactivated influenza vaccine contains thimerosal, a preservative that contains mercury. Some people believe thimerosal may be related to developmental problems in children. In 2004 the Institute of Medicine published a report concluding that, based on scientific studies, there is no evidence of such a relationship. If you are concerned about thimerosal, ask your doctor about thimerosal-free influenza vaccine.

3 Who should get inactivated influenza vaccine?

People 6 months of age and older can receive inactivated influenza vaccine. It is recommended for **anyone who is at risk of complications from influenza or more likely to require medical care:**

- **All children** from 6 months up to 5 years of age.
- Anyone **50 years of age or older**.
- Anyone 6 months to 18 years of age on **long-term aspirin treatment** (they could develop Reye Syndrome if they got influenza).
- Women who will be **pregnant** during influenza season.
- Anyone with **long-term health problems** with:
  - heart disease - kidney disease
  - lung disease - metabolic disease, such as diabetes
  - asthma - anemia, and other blood disorders
- Anyone with a **weakened immune system** due to:
  - HIV/AIDS or other diseases affecting the immune system
  - long-term treatment with drugs such as steroids
  - cancer treatment with x-rays or drugs
- Anyone with certain **muscle or nerve disorders** (such as seizure disorders or severe cerebral palsy) that can lead to breathing or swallowing problems.
- **Residents of nursing homes** and **other chronic-care facilities**.

Influenza vaccine is also recommended for anyone who lives with or cares for people at high risk for influenza-related complications:

- **Health care providers.**
- **Household contacts and caregivers of children** from birth up to 5 years of age.
- **Household contacts and caregivers** of people 50 years and older, and those with medical conditions that put them at higher risk for severe complications from influenza.

A yearly influenza vaccination should be *considered* for:

- People who provide **essential community services.**
- People living in **dormitories** or under other crowded conditions, to prevent outbreaks.
- People at high risk of influenza complications who **travel** to the Southern hemisphere between April and September, or to the tropics or in organized tourist groups at any time.

Influenza vaccine is also recommended for anyone who wants to **reduce the likelihood of becoming ill** with influenza or **spreading influenza to others**.

4 When should I get influenza vaccine?

Plan to get influenza vaccine in October or November if you can. But getting vaccinated in December, or even later, will still be beneficial in most years. You can get the vaccine as soon as it is available, and for as long as illness is occurring. Influenza illness can occur any time from November through May. Most cases usually occur in January or February.

Most people need one dose of influenza vaccine each year. **Children younger than 9 years of age getting influenza vaccine for the first time** should get 2 doses. For inactivated vaccine, these doses should be given at least 4 weeks apart.

Influenza vaccine may be given at the same time as other vaccines, including pneumococcal vaccine.

5 Some people should talk with a doctor before getting influenza vaccine

Some people should not get inactivated influenza vaccine or should wait before getting it.

- Tell your doctor if you have any **severe** (life-threatening) allergies. Allergic reactions to influenza vaccine are rare.
  - Influenza vaccine virus is grown in eggs. People with a severe egg allergy should not get the vaccine.
  - A severe allergy to any vaccine component is also a reason to not get the vaccine.
  - If you have had a severe reaction after a previous dose of influenza vaccine, tell your doctor.
- Tell your doctor if you ever had Guillain-Barré Syndrome (a severe paralytic illness, also called GBS). You may be able to get the vaccine, but your doctor should help you make the decision.
- People who are moderately or severely ill should usually wait until they recover before getting flu vaccine. If you are ill, talk to your doctor or nurse about whether to reschedule the vaccination. People with a **mild illness** can usually get the vaccine.

6 What are the risks from inactivated influenza vaccine?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small.

Serious problems from influenza vaccine are very rare. The viruses in inactivated influenza vaccine have been killed, so you cannot get influenza from the vaccine.

Mild problems:

- soreness, redness, or swelling where the shot was given
- fever • aches

If these problems occur, they usually begin soon after the shot and last 1-2 days.

Severe problems:

- Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the shot.
- In 1976, a certain type of influenza (swine flu) vaccine was associated with Guillain-Barré Syndrome (GBS). Since then, flu vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current flu vaccines, it would be no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which can be prevented by vaccination.

7 What if there is a severe reaction?

What should I look for?

Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

Call a doctor, or get the person to a doctor right away.

- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

  VAERS does not provide medical advice.

8 The National Vaccine Injury Compensation Program

In the event that you or your child has a serious reaction to a vaccine, a federal program has been created to help pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call **1-800-338-2382** or visit their website at **www.hrsa.gov/vaccinecompensation.**

9 How can I learn more?

- Ask your immunization provider. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit CDC's website at **www.cdc.gov/flu**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

DOCUMENT USED IN : CC IMMUNIZATIONS CLINIC

Attachment H: Mandated Forms

Texas Department of State Health Services

Addendum to Inactivated Influenza Vaccine Information Statement 2009-2010

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

***STATEMENT: I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the party who accepts assignment.**

Provider Identification Number: _____

Medicare Health Insurance Claim Number: _____

Information about person to receive vaccine (Please print)

Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one) M F

Address: Street	City	County	State	Zip
			TX	

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

x _____ Date _____

_____ Date _____
Witness

For Clinic/Office Use
Clinic/Office Address:

Date Vaccine Administered:

Vaccine Manufacturer:

Vaccine Lot Number:

Site of Injection:

Signature of Vaccine Administrator:

Title of Vaccine Administrator:

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Instructions: File this consent statement in the patient's chart.

Texas Department of State Health Services
C-93 (08/09)

CDC Interim VIS Revision 08/11/09

TEXAS Department of State Health Services

Texas Department of State Health Services

Addendum to Live, Intranasal Influenza Vaccine Information Statement 2009-2010

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: ☐ Live, Intranasal Influenza Vaccine

Information about person to receive vaccine (Please print)

Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one) M F

Address: Street	City	County	State	Zip
			TX	

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

x _____ Date _____

_____ Date _____
Witness

For Clinic/Office Use
Clinic/Office Address:

Date Vaccine Administered:

Vaccine Manufacturer:

Vaccine Lot Number:

Site of Administration:

Signature of Vaccine Administrator:

Title of Vaccine Administrator:

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Texas Department of State Health Services
C-87 (08/09)

CDC VIS Revision 08/11/09

POLIO VACCINE

WHAT YOU NEED TO KNOW

1 What is polio?

Polio is a disease caused by a virus. It enters a child's (or adult's) body through the mouth. Sometimes it does not cause serious illness. But sometimes it causes *paralysis* (can't move arm or leg). It can kill people who get it, usually by paralyzing the muscles that help them breathe.

Polio used to be very common in the United States. It paralyzed and killed thousands of people a year before we had a vaccine for it.

2 Why get vaccinated?

Inactivated Polio Vaccine (IPV) can prevent polio.

History: A 1916 polio epidemic in the United States killed 6,000 people and paralyzed 27,000 more. In the early 1950's there were more than 20,000 cases of polio each year. **Polio vaccination was begun in 1955.** By 1960 the number of cases had dropped to about 3,000, and by 1979 there were only about 10. The success of polio vaccination in the U.S. and other countries sparked a world-wide effort to eliminate polio.

Today: No wild polio has been reported in the United States for over 20 years. But the disease is still common in some parts of the world. It would only take one case of polio from another country to bring the disease back if we were not protected by vaccine. If the effort to eliminate the disease from the world is successful, some day we won't need polio vaccine. Until then, we need to keep getting our children vaccinated.

3 Who should get polio vaccine and when?

IPV is a shot, given in the leg or arm, depending on age. Polio vaccine may be given at the same time as other vaccines.

Children

Most people should get polio vaccine when they are children. Children get 4 doses of IPV, at these ages:

- ✓ A dose at 2 months
- ✓ A dose at 4 months
- ✓ A dose at 6-18 months
- ✓ A booster dose at 4-6 years

Adults

Most adults do not need polio vaccine because they were already vaccinated as children. But three groups of adults are at higher risk and *should* consider polio vaccination:

(1) people traveling to areas of the world where polio is common,
(2) laboratory workers who might handle polio virus, and
(3) health care workers treating patients who could have polio.

Adults in these three groups who **have never been vaccinated against polio** should get 3 doses of IPV:

- ✓ The first dose at any time,
- ✓ The second dose 1 to 2 months later,
- ✓ The third dose 6 to 12 months after the second.

Adults in these three groups who **have had 1 or 2 doses** of polio vaccine in the past should get the remaining 1 or 2 doses. It doesn't matter how long it has been since the earlier dose(s).

Adults in these three groups who **have had 3 or more doses** of polio vaccine (either IPV or OPV) in the past may get a booster dose of IPV.

Ask your health care provider for more information.

Oral Polio Vaccine: No longer recommended

There are two kinds of polio vaccine: **IPV**, which is the shot recommended in the United States today, and a live, oral polio vaccine (**OPV**), which is drops that are swallowed.

Until recently OPV was recommended for most children in the United States. OPV helped us rid the country of polio, and it is still used in many parts of the world.

Both vaccines give immunity to polio, but OPV is better at keeping the disease from spreading to other people. However, for a few people (about one in 2.4 million), OPV actually causes polio. Since the risk of getting polio in the United States is now extremely low, experts believe that using oral polio vaccine is no longer worth the slight risk, except in limited circumstances which your doctor can describe. The polio shot (IPV) does not cause polio. **If you or your child will be getting OPV, ask for a copy of the OPV supplemental Vaccine Information Statement.**

Polio - 1/1/2000

4 Some people should not get IPV or should wait.

These people should not get IPV:

- Anyone who has ever had a life-threatening allergic reaction to the antibiotics **neomycin**, **streptomycin** or **polymyxin B** should not get the polio shot.
- Anyone who has a severe allergic reaction to a polio shot should not get another one.

These people should wait:

- Anyone who is moderately or severely ill at the time the shot is scheduled should usually wait until they recover before getting polio vaccine. People with minor illnesses, such as a cold, ***may*** be vaccinated.

Ask your health care provider for more information.

5 What are the risks from IPV?

Some people who get IPV get a sore spot where the shot was given. The vaccine used today has never been known to cause any serious problems, and most people don't have any problems at all with it.

However, a vaccine, like any medicine, could cause serious problems, such as a severe allergic reaction. *The risk of a polio shot causing serious harm, or death, is extremely small.*

6 What if there is a serious reaction?

What should I look for?
Look for any unusual condition, such as a serious allergic reaction, high fever, or unusual behavior.

If a serious allergic reaction occurred, it would happen within a few minutes to a few hours after the shot. Signs of a serious allergic reaction can include difficulty breathing, weakness, hoarseness or wheezing, a fast heart beat, hives, dizziness, paleness, or swelling of the throat

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS website at www.vaers.org, or by calling 1-800-822-7967.

  VAERS does not provide medical advice.

Reporting reactions helps experts learn about possible problems with vaccines.

7 The National Vaccine Injury Compensation Program

In the rare event that you or your child has a serious reaction to a vaccine, there is a federal program that can help pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call **1-800-338-2382** or visit the program's website at **http://www.hrsa.gov/osp/vicp**

8 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department's immunization program.
- Contact the Centers for Disease Control and Prevention (CDC):
  -Call **1-800-232-4636 (1-800-CDC-INFO)**
  -Visit the National Immunization Program's website at **http://www.cdc.gov/nip**

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention
National Immunization Program

Vaccine Information Statement
Polio (1/1/2000) 42 U.S.C. § 300aa-26

TEXAS Department of State Health Services

Texas Department of State Health Services

Addendum to Polio Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: ☐ Inactivated Polio Vaccine (IPV)

Information about person to receive vaccine (Please print)

Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one) M F

Address: Street	City	County	State	Zip

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

x _____ Date _____

_____ Date _____
Witness

For Clinic/Office Use

Clinic/Office Address:

Date Vaccine Administered:

Vaccine Manufacturer:

Vaccine Lot Number:

Site of Administration:

Signature of Vaccine Administrator:

Title of Vaccine Administrator:

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Texas Department of State Health Services
EC-90 (03/06)

CDC VIS Revision 01/01/00

MENINGOCOCCAL VACCINES

WHAT YOU NEED TO KNOW

1 What is meningococcal disease?

Meningococcal disease is a serious illness, caused by a bacteria. It is a leading cause of bacterial meningitis in children 2-18 years old in the United States.

Meningitis is an infection of fluid surrounding the brain and the spinal cord. Meningococcal disease also causes blood infections.

About 2,600 people get meningococcal disease each year in the U.S. 10-15% of these people die, in spite of treatment with antibiotics. Of those who live, another 11-19% lose their arms or legs, become deaf, have problems with their nervous systems, become mentally retarded, or suffer seizures or strokes.

Anyone can get meningococcal disease. But it is most common in infants less than one year of age and people with certain medical conditions, such as lack of a spleen. College freshmen who live in dormitories have an increased risk of getting meningococcal disease.

Meningococcal infections can be treated with drugs such as penicillin. Still, about 1 out of every ten people who get the disease dies from it, and many others are affected for life. This is why *preventing* the disease through use of meningococcal vaccine is important for people at highest risk.

2 Meningococcal vaccine

Two meningococcal vaccines are available in the U.S.:

- **Meningococcal polysaccharide vaccine (MPSV4)** has been available since the 1970s.
- **Meningococcal conjugate vaccine (MCV4)** was licensed in 2005.

Both vaccines can prevent **4 types** of meningococcal disease, including 2 of the 3 types most common in the United States and a type that causes epidemics in Africa. Meningococcal vaccines cannot prevent all types of the disease. But they do protect many people who might become sick if they didn't get the vaccine.

Both vaccines work well, and protect about 90% of those who get it. MCV4 is expected to give better, longer-lasting protection.

MCV4 should also be better at preventing the disease from spreading from person to person.

3 Who should get meningococcal vaccine and when?

A dose of MCV4 is recommended for children and adolescents 11 through 18 years of age.

This dose is normally given during the routine preadolescent immunization visit (at 11-12 years). But those who did not get the vaccine during this visit should get it at the earliest opportunity.

Meningococcal vaccine is also recommended for other people at increased risk for meningococcal disease:

- College freshmen living in dormitories.
- Microbiologists who are routinely exposed to meningococcal bacteria.
- U.S. military recruits.
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa.
- Anyone who has a damaged spleen, or whose spleen has been removed.
- Anyone who has terminal complement component deficiency (an immune system disorder).
- People who might have been exposed to meningitis during an outbreak.

MCV4 is the preferred vaccine for people 11-55 years of age in these risk groups, but MPSV4 can be used if MCV4 is not available. MPSV4 should be used for children 2-10 years old, and adults over 55, who are at risk.

DOCUMENT USED IN :
CC IMMUNIZATIONS CLINIC

How Many Doses?

People 2 years of age and older should get 1 dose. (Sometimes an additional dose is recommended for people who remain at high risk. Ask your provider.)

MPSV4 may be recommended for children 3 months to 2 years of age under special circumstances. These children should get 2 doses, 3 months apart.

4 Some people should not get meningococcal vaccine or should wait

- Anyone who has ever had a severe (life-threatening) **allergic reaction to a previous dose** of either meningococcal vaccine should not get another dose.
- Anyone who has a severe (life threatening) **allergy to any vaccine component** should not get the vaccine. Tell your doctor if you have any severe allergies.
- Anyone who is **moderately or severely ill** at the time the shot is scheduled should probably wait until they recover. Ask your doctor or nurse. People with a **mild illness** can usually get the vaccine.
- Anyone who has ever had **Guillain-Barré Syndrome** should talk with their doctor before getting MCV4.
- Meningococcal vaccines may be given to pregnant women. However, MCV4 is a new vaccine and has not been studied in pregnant women as much as MPSV4 has. It should be used only if clearly needed.
- Meningococcal vaccines may be given at the same time as other vaccines.

5 What are the risks from meningococcal vaccines?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of meningococcal vaccine causing serious harm, or death, is extremely small.

Mild problems

Up to about half of people who get meningococcal vaccines have mild side effects, such as redness or pain where the shot was given.

If these problems occur, they usually last for 1 or 2 days. They are more common after MCV4 than after MPSV4.

A small percentage of people who receive the vaccine develop a fever.

Severe problems

- Serious allergic reactions, within a few minutes to a few hours of the shot, are very rare.
- A serious nervous system disorder called **Guillain-Barré Syndrome** (or GBS) has been reported among some people who received MCV4. This happens so rarely that it is currently not possible to tell if the vaccine might be a factor. Even if it is, the risk is very small.

6 What if there is a moderate or severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS web site at www.vaers.org, or by calling 1-800-822-7967.

  VAERS does not provide medical advice.

7 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit CDC's National Immunization Program website at **www.cdc.gov/vaccines**
  - Visit CDC's meningococcal disease website at **www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal_g.htm**
  - Visit CDC's Travelers' Health website at **wwwn.cdc.gov/travel**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

TEXAS Department of State Health Services

Texas Department of State Health Services

Addendum to Meningococcal Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: ☐ Meningococcal Polysaccharide Vaccine (MPSV4)

☐ Meningococcal Conjugate Vaccine (MCV4)

Information about person to receive vaccine (Please print)

Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one) M F

Address: Street	City	County	State	Zip
			TX	

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

x _____ Date _____

_____ Date _____
Witness

For Clinic/Office Use

Clinic/Office Address:

Date Vaccine Administered:

Vaccine Manufacturer:

Vaccine Lot Number:

Site of Administration:

Signature of Vaccine Administrator:

Title of Vaccine Administrator:

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Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA Privacy Notice.

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Instructions: File this consent statement in the patient's chart.

Texas Department of State Health Services
C-96 (08/07)

CDC Interim VIS Revision (08/16/07)

MEASLES MUMPS & RUBELLA VACCINES

WHAT YOU NEED TO KNOW

1 Why get vaccinated?

Measles, mumps, and rubella are serious diseases.

Measles

- Measles virus causes rash, cough, runny nose, eye irritation, and fever.
- It can lead to ear infection, pneumonia, seizures (jerking and staring), brain damage, and death.

Mumps

- Mumps virus causes fever, headache, and swollen glands.
- It can lead to deafness, meningitis (infection of the brain and spinal cord covering), painful swelling of the testicles or ovaries, and, rarely, death.

Rubella (German Measles)

- Rubella virus causes rash, mild fever, and arthritis (mostly in women).
- If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects.

You or your child could catch these diseases by being around someone who has them. They spread from person to person through the air.

Measles, mumps, and rubella (MMR) vaccine can prevent these diseases.

Most children who get their MMR shots will not get these diseases. Many more children would get them if we stopped vaccinating.

2 Who should get MMR vaccine and when?

Children should get 2 doses of MMR vaccine:

✓ The first at **12-15 months of age**
✓ and the second at **4-6 years of age**.

These are the recommended ages. But children can get the second dose at any age, as long as it is at least 28 days after the first dose.

Some **adults** should also get MMR vaccine: Generally, anyone 18 years of age or older, who was born after 1956, should get at least one dose of MMR vaccine, unless they can show that they have had either the vaccines or the diseases.

Ask your doctor or nurse for more information.

MMR vaccine may be given at the same time as other vaccines.

3 Some people should not get MMR vaccine or should wait

- People should not get MMR vaccine who have ever had a life-threatening allergic reaction to **gelatin**, the antibiotic **neomycin**, or to **a previous dose of MMR vaccine**.

- People who are moderately or severely ill at the time the shot is scheduled should usually wait until they recover before getting MMR vaccine.

- Pregnant women should wait to get MMR vaccine until after they have given birth. Women should avoid getting pregnant for 4 weeks after getting MMR vaccine.

- Some people should check with their doctor about whether they should get MMR vaccine, including anyone who:
  - Has HIV/AIDS, or another disease that affects the immune system
  - Is being treated with drugs that affect the immune system, such as steroids, for 2 weeks or longer.
  - Has any kind of cancer
  - Is taking cancer treatment with x-rays or drugs
  - Has ever had a low platelet count (a blood disorder)

Over . . .

had a transfusion or were given other blood products should ask their doctor when they may get MMR vaccine

Ask your doctor or nurse for more information.

4 What are the risks from MMR vaccine?

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of MMR vaccine causing serious harm, or death, is extremely small.

Getting MMR vaccine is much safer than getting any of these three diseases.

Most people who get MMR vaccine do not have any problems with it.

Mild Problems

- Fever (up to 1 person out of 6)
- Mild rash (about 1 person out of 20)
- Swelling of glands in the cheeks or neck (rare)

If these problems occur, it is usually within 7-12 days after the shot. They occur less often after the second dose.

Moderate Problems

- Seizure (jerking or staring) caused by fever (about 1 out of 3,000 doses)
- Temporary pain and stiffness in the joints, mostly in teenage or adult women (up to 1 out of 4)
- Temporary low platelet count, which can cause a bleeding disorder (about 1 out of 30,000 doses)

Severe Problems (Very Rare)

- Serious allergic reaction (less than 1 out of a million doses)
- Several other severe problems have been known to occur after a child gets MMR vaccine. But this happens so rarely, experts cannot be sure whether they are caused by the vaccine or not. These include:
  - Deafness
  - Long-term seizures, coma, or lowered consciousness
  - Permanent brain damage

5 What if there is a moderate or severe reaction?

What should I look for?

Any unusual conditions, such as a serious allergic reaction, high fever or behavior changes. Signs of a serious allergic reaction include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness within a few minutes to a few hours after the shot. A high fever or seizure, if it occurs, would happen 1 or 2 weeks after the shot.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.
  Or you can file this report through the VAERS web site at www.vaers.org, or by calling 1-800-822-7967.
  VAERS does not provide medical advice.

6 The National Vaccine Injury Compensation Program

In the rare event that you or your child has a serious reaction to a vaccine, a federal program has been created to help you pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call **1-800-338-2382** or visit the program's website at www.hrsa.gov/osp/vicp

7 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department's immunization program.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit the National Immunization Program's website at www.cdc.gov/nip

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention
National Immunization Program

Vaccine Information Statement
MMR (1/15/03) 42 U.S.C. § 300aa-26

DOCUMENT USED IN : CC IMMUNIZATIONS CLINIC

Attachment H: Mandated Forms

TEXAS Department of State Health Services

Texas Department of State Health Services

Addendum to Measles, Mumps, and Rubella Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: ☐ (MMR) Measles, Mumps, and Rubella ☐ Measles and Rubella ☐ Measles ☐ Mumps ☐ Rubella

Information about person to receive vaccine (Please print)

Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one) M F

Address: Street	City	County	State	Zip
			TX	

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

x _____ Date _____

_____ Date _____
Witness

For Clinic/Office Use

Clinic/Office Address:

Date Vaccine Administered:

Vaccine Manufacturer:

Vaccine Lot Number:

Site of Administration:

Signature of Vaccine Administrator:

Title of Vaccine Administrator:

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Texas Department of State Health Services
EC-92 (03/06)

CDC VIS Revision 1/15/2003

DOCUMENT USED IN : CC IMMUNIZATIONS CLINIC

Attachment H: Mandated Forms

TEXAS Department of State Health Services

Texas Department of State Health Services

Addendum to Six Vaccines
Vaccine Information Statement

1. I agree that the person named below will get the vaccines checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccines listed below.
3. I know the risks of the diseases these vaccines prevent.
4. I know the benefits and risks of the vaccines.
5. I have had a chance to ask questions about the diseases the vaccines prevent, the vaccines, and how the vaccines are given.
6. I know that the person named below will have the vaccines put in his/her body to prevent the diseases these vaccines prevent.
7. I am an adult who can legally consent for the person named below to get the vaccines. I freely and voluntarily give my signed permission for these vaccines.

Vaccine(s) to be given: ☐ Hepatitis B ☐ Polio ☐ Pneumococcal Disease ☐ Diphtheria, Tetanus, & Pertussis ☐ Rotavirus ☐ Hib

Information about person to receive vaccine (Please print)

Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one) M F

Address: Street	City	County	State	Zip
			TX	

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

x _____ Date _____

_____ Date _____
Witness

For Clinic/Office Use

Clinic/Office Address:
Date Vaccine Administered:
Vaccine Manufacturer:
Vaccine Lot Number:
Site of Administration:
Signature of Vaccine Administrator:
Title of Vaccine Administrator:

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Texas Department of State Health Services
C-113 (09/08)

CDC Interim VIS Revision (09/18/08)

PNEUMOCOCCAL CONJUGATE VACCINE

WHAT YOU NEED TO KNOW

1 Why get vaccinated?

Infection with *Streptococcus pneumoniae* bacteria can cause serious illness and death. Invasive pneumococcal disease is responsible for about 200 deaths each year among children under 5 years old. It is the leading cause of bacterial meningitis in the United States. (Meningitis is an infection of the covering of the brain).

Pneumococcal infection causes severe disease in children under five years old. Before a vaccine was available, each year pneumococcal infection caused:

- over 700 cases of meningitis,
- 13,000 blood infections, and
- about 5 million ear infections.

It can also lead to other health problems, including:

- pneumonia,
- deafness,
- brain damage.

Children under 2 years old are at highest risk for serious disease.

Pneumococcus bacteria are spread from person to person through close contact.

Pneumococcal infections can be hard to treat because the bacteria have become resistant to some of the drugs that have been used to treat them. This makes **prevention** of pneumococcal infections even more important.

Pneumococcal conjugate vaccine can help prevent serious pneumococcal disease, such as meningitis and blood infections. It can also prevent some ear infections. But ear infections have many causes, and pneumococcal vaccine is effective against only some of them.

2 Pneumococcal conjugate vaccine

Pneumococcal conjugate vaccine is approved for infants and toddlers. Children who are vaccinated when they are infants will be protected when they are at greatest risk for serious disease.

Some older children and adults may get a different vaccine called pneumococcal polysaccharide vaccine. There is a separate Vaccine Information Statement for people getting this vaccine.

3 Who should get the vaccine and when?

- **Children Under 2 Years of Age**

  The routine schedule for pneumococcal conjugate vaccine is 4 doses, one dose at each of these ages:

  ✓ **2 months** ✓ **6 months**
  ✓ **4 months** ✓ **12-15 months**

  Children who weren't vaccinated at these ages can still get the vaccine. The number of doses needed depends on the child's age. Ask your health care provider for details.

- **Children Between 2 and 5 Years of Age**

  Pneumococcal conjugate vaccine is also recommended for children between 2 and 5 years old who have not already gotten the vaccine and are at high risk of serious pneumococcal disease. This includes children who:

  S have sickle cell disease,
  S have a damaged spleen or no spleen,
  S have HIV/AIDS,
  S have other diseases that affect the immune system, such as diabetes, cancer, or liver disease, or who
  S take medications that affect the immune system, such as chemotherapy or steroids, or
  S have chronic heart or lung disease.

  The vaccine should be considered for all other children under 5 years, especially those at higher risk of serious pneumococcal disease. This includes children who:

  S are under 3 years of age,
  S are of Alaska Native, American Indian or African American descent, or
  S attend group day care.

  The number of doses needed depends on the child's age. Ask your health care provider for more details.

Pneumococcal conjugate vaccine may be given at the same time as other vaccines.

4 Some children should not get pneumococcal conjugate vaccine or should wait

Children should not get pneumococcal conjugate vaccine if they had a serious (life-threatening) allergic reaction to a previous dose of this vaccine, or have a severe allergy to a vaccine component. Tell your health-care provider if your child has ever had a severe reaction to any vaccine, or has any severe allergies.

Children with minor illnesses, such as a cold, may be vaccinated. But children who are moderately or severely ill should usually wait until they recover before getting the vaccine.

5 What are the risks from pneumococcal conjugate vaccine?

In studies (nearly 60,000 doses), pneumococcal conjugate vaccine was associated with only mild reactions:

- Up to about 1 infant out of 4 had redness, tenderness, or swelling where the shot was given.
- Up to about 1 out of 3 had a fever of over 100.4°F, and up to about 1 in 50 had a higher fever (over 102.2°F).
- Some children also became fussy or drowsy, or had a loss of appetite.

So far, no serious reactions have been associated with this vaccine. However, a vaccine, like any medicine, could cause serious problems, such as a severe allergic reaction. The risk of this vaccine causing serious harm, or death, is extremely small.

6 What if there is a moderate or severe reaction?

What should I look for?

Look for any unusual condition, such as a serious allergic reaction, high fever, or unusual behavior.

Serious allergic reactions are extremely rare with any vaccine. If one were to occur, it would most likely be within a few minutes to a few hours after the shot. Signs can include:

- difficulty breathing
- hoarseness or wheezing
- swelling of the throat
- weakness
- fast heart beat
- dizziness
- hives
- paleness

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS web site at www.vaers.org, or by calling 1-800-822-7967.

  VAERS does not provide medical advice.

7 The National Vaccine Injury Compensation Program

In the rare event that you or your child has a serious reaction to a vaccine, a federal program has been created to help pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call **1-800-338-2382** or visit their website at **http://www.hrsa.gov/osp/vicp**

8 How can I learn more?

- Ask your health care provider. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department's immunization program.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit the National Immunization Program's website at **http://www.cdc.gov/nip**

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention
National Immunization Program

Vaccine Information Statement
Pneumococcal Conjugate Vaccine (9/30/02) 42 U.S.C. § 300aa-26

TEXAS Department of State Health Services

Texas Department of State Health Services

Addendum to Pneumococcal Conjugate Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: ☐ Pneumococcal Conjugate Vaccine

Information about person to receive vaccine (Please print)

Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one) M F

Address: Street	City	County	State	Zip
			TX	

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

x _____ Date _____

_____ Date _____
Witness

For Clinic/Office Use

Clinic/Office Address:

Date Vaccine Administered:

Vaccine Manufacturer:

Vaccine Lot Number:

Site of Injection:

Signature of Vaccine Administrator:

Title of Vaccine Administrator:

PRIVACY NOTIFICATION - With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA Privacy Notice.

Notice: Alterations or changes to this publication is prohibited without the express written consent of the Texas Department of State Health Services, Immunization Branch.

Instructions: File this consent statement in the patient's chart.

Texas Department of State Health Services
EC-85 (03/06)

CDC VIS Revision 09/30/02

PNEUMOCOCCAL POLYSACCHARIDE VACCINE

WHAT YOU NEED TO KNOW

1 Why get vaccinated?

Pneumococcal disease is a serious disease that causes much sickness and death. In fact, pneumococcal disease kills more people in the United States each year than all other vaccine-preventable diseases combined. Anyone can get pneumococcal disease. However, some people are at greater risk from the disease. These include people 65 and older, the very young, and people with special health problems such as alcoholism, heart or lung disease, kidney failure, diabetes, HIV infection, or certain types of cancer.

Pneumococcal disease can lead to serious infections of the lungs (pneumonia), the blood (bacteremia), and the covering of the brain (meningitis). About 1 out of every 20 people who get pneumococcal pneumonia dies from it, as do about 2 people out of 10 who get bacteremia and 3 people out of 10 who get meningitis. People with the special health problems mentioned above are even more likely to die from the diease.

Drugs such as penicillin were once effective in treating these infections; but the disease has become more resistant to these drugs, making treatment of pneumococcal infections more difficult. This makes prevention of the disease through vaccination even more important.

2 Pneumococcal polysaccharide vaccine (PPV)

The pneumococcal polysaccharide vaccine (PPV) protects against 23 types of pneumococcal bacteria. Most healthy adults who get the vaccine develop protection to most or all of these types within 2 to 3 weeks of getting the shot. Very old people, children under 2 years of age, and people with some long-term illnesses might not respond as well or at all.

3 Who should get PPV?

- All adults 65 years of age or older.
- Anyone over 2 years of age who has a long-term health problem such as:
  - heart disease
  - lung disease
  - sickle cell disease
  - diabetes
  - alcoholism
  - cirrhosis
  - leaks of cerebrospinal fluid
- Anyone over 2 years of age who has a disease or condition that lowers the body's resistance to infection, such as:
  - Hodgkin's disease
  - lymphoma, leukemia
  - kidney failure
  - multiple myeloma
  - nephrotic syndrome
  - HIV infection or AIDS
  - damaged spleen, or no spleen
  - organ transplant
- Anyone over 2 years of age who is taking any drug or treatment that lowers the body's resistance to infection, such as:
  - long-term steroids
  - certain cancer drugs
  - radiation therapy
- Alaskan Natives and certain Native American populations.

4 How many doses of PPV are needed?

Usually one dose of PPV is all that is needed.

However, under some circumstances a second dose may be given.

- A second dose is recommended for those people aged 65 and older who got their first dose when they were under 65, if 5 or more years have passed since that dose.
- A second dose is also recommended for people who:
  - have a damaged spleen or no spleen
  - have sickle-cell disease
  - have HIV infection or AIDS
  - have cancer, leukemia, lymphoma, multiple myeloma
  - have kidney failure
  - have nephrotic syndrome
  - have had an organ or bone marrow transplant
  - are taking medication that lowers immunity (such as chemotherapy or long-term steroids)

Children 10 years old and younger may get this second dose 3 years after the first dose. Those older than 10 should get it 5 years after the first dose.

5 Other facts about getting the vaccine

- Otherwise healthy children who often get ear infections, sinus infections, or other upper respiratory diseases do not need to get PPV because of these conditions.
- PPV may be less effective in some people, especially those with lower resistance to infection. But these people should still be vaccinated, because they are more likely to get seriously ill from pneumococcal disease.
- **Pregnancy**: The safety of PPV for pregnant women has not yet been studied. There is no evidence that the vaccine is harmful to either the mother or the fetus, but pregnant women should consult with their doctor before being vaccinated. Women who are at high risk of pneumococcal disease should be vaccinated before becoming pregnant, if possible.

6 What are the risks from PPV?

PPV is a very safe vaccine.

About half of those who get the vaccine have very mild side effects, such as redness or pain where the shot is given.

Less than 1% develop a fever, muscle aches, or more severe local reactions.

Severe allergic reactions have been reported very rarely.

As with any medicine, there is a very small risk that serious problems, even death, could occur after getting a vaccine.

Getting the disease is much more likely to cause serious problems than getting the vaccine.

7 What if there is a serious reaction?

What should I look for?

- Severe allergic reaction (hives, difficulty breathing, shock).

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.
  Or you can file this report through the VAERS web site at www.vaers.org, or by calling 1-800-822-7967.
  VAERS does not provide medical advice.

8 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit the National Immunization Program website at **www.cdc.gov/nip**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL IMMUNIZATION PROGRAM

DOCUMENT USED IN : CC IMMUNIZATIONS CLINIC

Attachment H: Mandated Forms

TEXAS Department of State Health Services

Texas Department of State Health Services

Addendum to Pneumococcal Polysaccharide Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

***STATEMENT:I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the party who accepts assignment.**

Provider Identification Number: _____

Medicare Health Insurance Claim Number: _____

Vaccine to be given: ☐ Pneumococcal Polysaccharide

Information about person to receive vaccine (Please print)

Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one) M F

Address: Street	City	County	State	Zip
			TX	

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

x _____ Date _____

_____ Date _____
Witness

For Clinic/Office Use

Clinic/Office Address:

Date Vaccine Administered:

Vaccine Manufacturer:

Vaccine Lot Number:

Site of Administration:

Signature of Vaccine Administrator:

Title of Vaccine Administrator:

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Instructions: File this consent statement in the patient's chart.

Texas Department of State Health Services
EC-86 (03/06)

CDC VIS Revision 07/29/97

RABIES VACCINE

WHAT YOU NEED TO KNOW

1 What is rabies?

Rabies is a serious disease. It is caused by a virus.

Rabies is mainly a disease of animals. Humans get rabies when they are bitten by infected animals.

At first there might not be any symptoms. But weeks, or even years after a bite, rabies can cause pain, fatigue, headaches, fever, and irritability. These are followed by seizures, hallucinations, and paralysis. Rabies is almost always fatal.

Wild animals - especially bats - are the most common source of human rabies

infection in the United States. Skunks, raccoons, dogs, and cats can also transmit the disease.

Human rabies is rare in the United States. There have been only 39 cases diagnosed since 1990. However, between 16,000 and 39,000 people are treated each year for possible exposure to rabies after animal bites. Also, rabies is far more common in other parts of the world, with about 40,000 - 70,000 rabies-related deaths each year. Bites from unvaccinated dogs cause most of these cases.

Rabies vaccine can prevent rabies.

2 Rabies vaccine

Rabies vaccine is given to people at high risk of rabies to protect them if they are exposed. It can also prevent the disease if it is given to a person *after* they have been exposed.

Rabies vaccine is made from killed rabies virus. It cannot cause rabies.

3 Who should get rabies vaccine and when?

Preventive Vaccination (No Exposure)

- People at high risk of exposure to rabies, such as veterinarians, animal handlers, rabies laboratory workers, spelunkers, and rabies biologics production workers should be offered rabies vaccine.
- The vaccine should also be considered for:
  - People whose activities bring them into frequent contact with rabies virus or with possibly rabid animals.
  - International travelers who are likely to come in contact with animals in parts of the world where rabies is common.

The pre-exposure schedule for rabies vaccination is **3 doses**, given at the following times:

Dose 1: As appropriate
Dose 2: 7 days after Dose 1
Dose 3: 21 days ***or*** 28 days after Dose 1

For laboratory workers and others who may be repeatedly exposed to rabies virus, periodic testing for immunity is recommended, and booster doses should be given as needed. (Testing or booster doses are not recommended for travelers.) Ask your doctor for details.

Vaccination After an Exposure

Anyone who has been bitten by an animal, or who otherwise may have been exposed to rabies, should see a doctor immediately.

- A person who is exposed and has never been vaccinated against rabies should get **5 doses** of rabies vaccine - one dose right away, and additional doses on the 3rd, 7th, 14th, and 28th days. They should also get a shot of *Rabies Immune Globulin* at the same time as the first dose. This gives immediate protection.
- A person who **has** been previously vaccinated should get **2 doses** of rabies vaccine - one right away and another on the 3rd day. Rabies Immune Globulin is not needed.

4 Tell your doctor if . . .

Talk with a doctor before getting rabies vaccine if you:

1) ever had a serious (life-threatening) allergic reaction to a previous dose of rabies vaccine, or to any component of the vaccine,

2) have a weakened immune system because of:
   - HIV/AIDS or another disease that affects the immune system,
   - treatment with drugs that affect the immune system, such as steroids,
   - cancer, or cancer treatment with radiation or drugs.

If you have a minor illness, such as a cold, you can be vaccinated. If you are moderately or severely ill, you should probably wait until you recover before getting a routine (non-exposure) dose of rabies vaccine.

If you have been exposed to rabies virus, you should get the vaccine regardless of any other illnesses you may have.

5 What are the risks from rabies vaccine?

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small. Serious problems from rabies vaccine are very rare.

Mild problems:
- soreness, redness, swelling, or itching where the shot was given (30% - 74%)
- headache, nausea, abdominal pain, muscle aches, dizziness (5% - 40%)

Moderate problems:
- hives, pain in the joints, fever (about 6% of booster doses)
- illness resembling Guillain-Barré Syndrome (GBS), with complete recovery (very rare)

Other nervous system disorders have been reported after rabies vaccine, but this happens so rarely that it is not known whether they are related to the vaccine.

NOTE: Several brands of rabies vaccine are available in the United States, and reactions may vary between brands. Your provider can give you more information about a particular brand.

6 What if there is a moderate or severe reaction?

What should I look for?
- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?
- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS website at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

  VAERS does not provide medical advice.

7 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Visit CDC's rabies website at **www.cdc.gov/ncidod/dvrd/rabies**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL IMMUNIZATION PROGRAM

DOCUMENT USED IN : CC IMMUNIZATIONS CLINIC

Attachment F: Mandated Forms

Texas Department of State Health Services

Addendum to Rabies Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease, the vaccine, and how the vaccine is given.
6. I know that the person named below will have a vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: ☐ Rabies Vaccine ☐ Immunoglobulin

Information about person to receive rabies vaccine or immunoglobulin (Please type or print clearly)

Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Age

Address: Street	City	County	State	Zip
			TX	

x_____ Date _____
Signature of person to receive rabies biologicals or person authorized to make the request (parent or guardian) (mm/dd/yy)

x_____ Date _____
Signature of person who reviewed this form with recipient of rabies biologicals (witness) (mm/dd/yy)

x_____ Date _____
Signature of attending physician (mm/dd/yy)

FOR CLINIC ONLY

Clinic ID

VACCINE	DOSAGE	DATE	LOT NO.
HRIG			
#1 HDCV/PCEC			
#2 HDCV/PCEC			
#3 HDCV/PCEC			
#4 HDCV/PCEC			
#5 HDCV/PCEC			

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Instructions: File this consent statement in the patient's chart.

Texas Department of State Health Services
EC-99 (01/06)

CDC VIS Revision (01/12/06)

DOCUMENT USED IN :
CC IMMUNIZATIONS CLINIC

Vaccine Information Statement

ROTAVIRUS VACCINE

WHAT YOU NEED TO KNOW

1 What is rotavirus?

Rotavirus is a virus that causes severe diarrhea, mostly in babies and young children. It is often accompanied by vomiting and fever.

Rotavirus is not the only cause of severe diarrhea, but it is one of the most serious. Each year in the United States rotavirus is responsible for:

- more than 400,000 doctor visits
- more than 200,000 emergency room visits
- 55,000 to 70,000 hospitalizations
- 20-60 deaths

Almost all children in the U.S. are infected with rotavirus before their 5th birthday.

Children are most likely to get rotavirus disease between November and May, depending on the part of the country.

Your child can get rotavirus infection by being around other children who are already infected.

2 Rotavirus vaccine

Better hygiene and sanitation have not been very good at reducing rotavirus disease. Rotavirus vaccine is the best way to protect children against rotavirus disease.

Rotavirus vaccine is an oral (swallowed) vaccine; it is not given by injection.

Rotavirus vaccine will not prevent diarrhea or vomiting caused by other germs, but it is very good at preventing diarrhea and vomiting caused by rotavirus. About 98% of children who get the vaccine are protected from *severe* rotavirus diarrhea, and about 74% do not get rotavirus diarrhea at all.

Children who get the vaccine are also much less likely to be hospitalized or to see a doctor because of rotavirus infection.

3 Who should get rotavirus vaccine and when?

Children should get 3 doses of rotavirus vaccine. They are recommended at these ages:

First Dose:	2 months of age
Second Dose:	4 months of age
Third Dose:	6 months of age

- The first dose should be given between 6 and 12 weeks of age. The vaccine has not been studied when started among children outside that age range.
- Children should have gotten all 3 doses by 32 weeks of age.

Rotavirus vaccine may be given at the same time as other childhood vaccines.

Children who get the vaccine may be fed normally afterward.

4 Some children should not get rotavirus vaccine or should wait

- A child who has had a severe (life-threatening) allergic reaction to a dose of rotavirus vaccine should not get another dose. A child who has a severe (life threatening) allergy to any component of rotavirus vaccine should not get the vaccine. Tell your doctor if your child has any severe allergies that you know of.
- Children who are moderately or severely ill at the time the vaccination is scheduled should probably wait until they recover. This includes children who have diarrhea or vomiting. Ask your doctor or nurse. Children with mild illnesses should usually get the vaccine.
- Check with your doctor if your child has any ongoing digestive problems.

Rotavirus	4/12/06

- Check with your doctor if your child's immune system is weakened because of:
  - HIV/AIDS, or any other disease that affects the immune system
  - treatment with drugs such as long-term steroids
  - cancer, or cancer treatment with x-rays or drugs

- Check with your doctor if your child recently had a blood transfusion or received any other blood product (such as immune globulin).

> In the late 1990s a different type of rotavirus vaccine was used. This vaccine was found to be associated with an uncommon type of bowel obstruction called "intussusception," and was taken off the market.
>
> The new rotavirus vaccine has been tested with more than 70,000 children and has not been associated with intussusception.
>
> However, once a person has had intussusception, from any cause, they are at higher risk for getting it again. So as a precaution, it is suggested that if a child has had intussusception they should not get rotavirus vaccine.

5 What are the risks from rotavirus vaccine?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of rotavirus vaccine causing serious harm, or death, is extremely small.

Getting rotavirus vaccine is much safer than getting the disease.

Mild problems

Children are slightly (1-3%) more likely to have mild, temporary diarrhea or vomiting within 7 days after getting a dose of rotavirus vaccine than children who have not gotten the vaccine.

Moderate or severe reactions have not been associated with this vaccine.

If rare reactions occur with any new product, they may not be identified until thousands, or millions, of people have used it. Like all vaccines, rotavirus vaccine will continue to be monitored for unusual or severe problems.

6 What if there is a moderate or severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

  VAERS does not provide medical advice.

7 The National Vaccine Injury Compensation Program

In the rare event that you or your child has a serious reaction to a vaccine, a federal program has been created to help pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call **1-800-338-2382** or visit their website at **www.hrsa.gov/vaccinecompensation**.

8 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit CDC's National Immunization Program website at: **www.cdc.gov/nip**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL IMMUNIZATION PROGRAM

DOCUMENT USED IN : CC IMMUNIZATIONS CLINIC

Attachment H: Mandated Forms

Texas Department of State Health Services

Addendum to Rotavirus Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: ☐ Rotavirus

Information about person to receive vaccine (Please print)				
Name: Last First Middle Initial			Birthdate (mm/dd/yy)	Sex (circle one) **M** **F**
Address: Street	City	County	State **TX**	Zip
Signature of person to receive vaccine or person authorized to make the request (parent or guardian): x _____ Date _____				
_____ Date _____ Witness				

For Clinic/Office Use
Clinic/Office Address:
Date Vaccine Administered:
Vaccine Manufacturer:
Vaccine Lot Number:
Site of Administration:
Signature of Vaccine Administrator:
Title of Vaccine Administrator:

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Texas Department of State Health Services
EC-110 (04/06)

CDC VIS Interim Revision 04/12/06

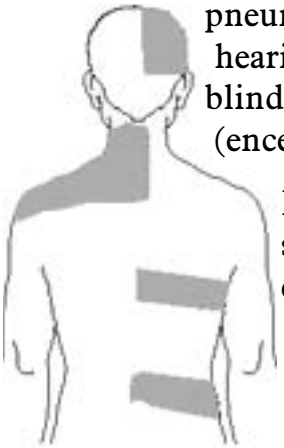
SHINGLES VACCINE

WHAT YOU NEED TO KNOW

1 What is shingles?

Shingles is a painful skin rash, often with blisters. It is also called Herpes Zoster.

A shingles rash usually appears on one side of the face or body and lasts from 2 to 4 weeks. Its main symptom is pain, which can be quite severe. Other symptoms of shingles can include fever, headache, chills and upset stomach. Very rarely, a shingles infection can lead to pneumonia, hearing problems, blindness, brain inflammation (encephalitis) or death.



For about 1 person in 5, severe pain can continue even after the rash clears up. This is called **post-herpetic neuralgia**.

Shingles is caused by the Varicella Zoster virus, the same virus that causes chickenpox. Only someone who has had a case of chickenpox – or gotten chicken-pox vaccine – can get shingles. The virus stays in your body. It can reappear many years later to cause a case of shingles.

You can't catch shingles from another person with shingles. However, a person who has never had chickenpox (or chickenpox vaccine) could get **chickenpox** from someone with shingles. This is not very common.

Shingles is far more common in people 50 and older than in younger people. It is also more common in people whose immune systems are weakened because of a disease such as cancer, or drugs such as steroids or chemotherapy. At least 1 million people a year in the United States get shingles.

2 Shingles vaccine

A vaccine for shingles was licensed in 2006. In clinical trials, the vaccine prevented shingles in about half of people 60 years of age and older. It can also reduce the pain associated with shingles.

A **single dose** of shingles vaccine is indicated for adults **60 years of age and older**.

3 Some people should not get shingles vaccine or should wait

A person should not get shingles vaccine who:

- has ever had a life-threatening **allergic reaction** to **gelatin**, the antibiotic **neomycin**, or **any other component of shingles vaccine**. Tell your doctor if you have any severe allergies.
- has a **weakened immune system** because of
  - HIV/AIDS or another disease that affects the immune system,
  - treatment with drugs that affect the immune system, such as steroids,
  - cancer treatment such as radiation or chemotherapy,
  - a history of cancer affecting the bone marrow or lymphatic system, such as leukemia or lymphoma.
- has active, untreated **tuberculosis**.

Shingles 9/11/06

to pregnant, or might be pregnant. Women should not become pregnant until at least three months after getting shingles vaccine.

Someone with a minor illness, such as a cold, may be vaccinated. But anyone who is moderately or severely ill should usually wait until they recover before getting the vaccine. This includes anyone with a temperature of 101.3°F or higher.

4 What are the risks from shingles vaccine?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. However, the risk of a vaccine causing serious harm, or death, is extremely small.

No serious problems have been identified with shingles vaccine.

Mild Problems

- Redness, soreness, swelling, or itching at the site of the injection (about 1 person in 3).
- Headache (about 1 person in 70).

Like all vaccines, shingles vaccine is being closely monitored for unusual or severe problems.

5 What if there is a moderate or severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness. These usually occur within the first few hours after vaccination.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

  VAERS does not provide medical advice.

6 How can I learn more?

- Your provider can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit CDC's website at **www.cdc.gov/nip**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR IMMUNIZATION AND RESPIRATORY DISEASES

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Attachment H: Mandated Forms

Texas Department of State Health Services

Addendum to Shingles Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: ☐ Shingles Vaccine

Information about person to receive vaccine (Please print)				
Name: Last First Middle Initial			Birthdate (mm/dd/yy)	Sex (circle one) **M** **F**
Address: Street	City	County	State **TX**	Zip
Signature of person to receive vaccine or person authorized to make the request (parent or guardian): x _____ Date _____				
_____ Date _____ Witness				

For Clinic/Office Use
Clinic/Office Address:
Date Vaccine Administered:
Vaccine Manufacturer:
Vaccine Lot Number:
Site of Administration:
Signature of Vaccine Administrator:
Title of Vaccine Administrator:

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Instructions: File this consent statement in the patient's chart.

Texas Department of State Health Services
EC-112 (09/06)

CDC VIS Interim Revision 09/11/06

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TETANUS AND DIPHTHERIA VACCINE (Td)

What you need to know before you or your child gets the vaccine

ABOUT THE DISEASES

Tetanus (lockjaw) and diphtheria are serious diseases. Tetanus is caused by a germ that enters the body through a cut or wound. Diphtheria spreads when germs pass from an infected person to the nose or throat of others.

Tetanus causes	Diphtheria causes
serious, painful spasms of all muscles	a thick coating in the nose, throat, or airway
It can lead to: - "locking" of the jaw so the patient cannot open his or her mouth or swallow	**It can lead to:** - breathing problems - heart failure - paralysis - death

ABOUT THE VACCINES

Benefits of the vaccines

Vaccination is the best way to protect against tetanus and diphtheria, Because of vaccination, there are many fewer cases of these diseases. Cases are rare in children because most get DTP (Diphtheria, Tetanus, and Pertussis), DTaP (Diphtheria, Tetanus, and acellular Pertussis), or DT (Diphtheria and Tetanus) vaccines. There would be many more cases if we stopped vaccinating people.

When should you get Td vaccine?

Td is made for people 7 years of age and older.

People who have not gotten at least 3 doses of any tetanus and diphtheria vaccine (DTP, DTaP or DT) during their lifetime should do so using Td. After a person gets the third dose, a Td dose is needed every 10 years ail through life.

Other vaccines may be given at the same time as Td.

Tell your doctor or nurse if the person getting the vaccine:

- ever had a serious allergic reaction or other problem with Td, or any other tetanus and diphtheria vaccine (DTP, DTaP or DT)
- now has a moderate or severe illness
- is pregnant

If you are not sure, ask your doctor or nurse.

What are the risks from Td vaccine?

As with any medicine, there are very small risks that serious problems, even death, could occur after getting a vaccine.

The risks from the vaccine are <u>much smaller</u> than the risks from the diseases if people stopped using vaccine.

Almost all people who get Td have no problems from it.

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention

Mild problems

If these problems occur, they usually start within hours to a day or two after vaccination. They may last 1-2 days:

- soreness, redness, or swelling where the shot was given

These problems can be worse in adults who get Td vaccine very often.

Acetaminophen or ibuprofen (non-aspirin) may be used to reduce soreness.

Severe problems

These problems happen very rarely:

- serious allergic reaction
- deep, aching pain and muscle wasting in upper arm(s), This starts 2 days to 4 weeks after the shot, and may last many months.

What to do if there is a serious reaction:

☞ Call a doctor or get the person to a doctor right away,

☞ Write down what happened and the date and time it happened.

☞ Ask your doctor, nurse, or health department to file a Vaccine Adverse Event Report form or call:
(800) 822-7967 (toll-free)

The **National Vaccine Injury Compensation Program** gives compensation (payment) for persons thought to be injured by vaccines. For details call:
(800) 338-2382 (toll-free)

If you want to learn more, ask your doctor or nurse. She/he can give you the vaccine package insert or suggest other sources of information.

Td 6/10/94 42 U.S.C. § 300aa-26

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TEXAS Department of State Health Services

Texas Department of State Health Services

Addendum to Tetanus and Diphtheria Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: ☐ Td (Tetanus and Diphtheria) Vaccine ☐ Tetanus

Information about person to receive vaccine (Please print)

Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one) M F

Address: Street	City	County	State	Zip
			TX	

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

x _____ Date _____

_____ Date _____
Witness

For Clinic/Office Use

Clinic/Office Address:

Date Vaccine Administered:

Vaccine Manufacturer:

Vaccine Lot Number:

Site of Administration:

Signature of Vaccine Administrator:

Title of Vaccine Administrator:

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Texas Department of State Health Services
EC-94 (03/06)

CDC VIS Revision 06/10/94

TETANUS, DIPHTHERIA, PERTUSSIS (Tdap) VACCINE

WHAT YOU NEED TO KNOW

1 Why get vaccinated?

Tdap (**T**etanus, **D**iphtheria, **P**ertussis) vaccine can protect adolescents and adults against three serious diseases.

Tetanus, diphtheria, and pertussis are all caused by bacteria. Diphtheria and pertussis are spread from person to person. Tetanus enters the body through cuts, scratches, or wounds.

TETANUS (Lockjaw) causes painful tightening of the muscles, usually all over the body.

- **It can lead to** "locking" of the jaw so the victim cannot open his mouth or swallow. Tetanus leads to death in up to 2 cases out of 10.

DIPHTHERIA causes a thick covering in the back of the throat.

- **It can lead to** breathing problems, paralysis, heart failure, and even death.

PERTUSSIS (Whooping Cough) causes severe coughing spells, vomiting, and disturbed sleep.

- **It can lead to** weight loss, incontinence, rib fractures and passing out from violent coughing, pneumonia, and hospitalization due to complications.

  In 2004 there were more than 25,000 cases of pertussis in the U.S. More than 8,000 of these cases were among adolescents and more than 7,000 were among adults. Up to 2 in 100 adolescents and 5 in 100 adults with pertussis are hospitalized or have complications.

2 Tdap and related vaccines

Vaccines for Adolescents and Adults

- **Tdap** was licensed in 2005. It is the first vaccine for adolescents and adults that protects against all three diseases.
- **Td** (tetanus and diphtheria) vaccine has been used for many years as booster doses for adolescents and adults. It does not contain pertussis vaccine.

Vaccines for Children Younger than 7 Years

- **DTaP** vaccine is given to children to protect them from these three diseases. Immunity can fade over time, and periodic "booster" doses are needed by adolescents and adults to keep immunity strong. (**DTP** is an older version of DTaP. It is no longer used in the United States.)
- **DT** contains diphtheria and tetanus vaccines. It is used for children younger than 7 who should not get pertussis vaccine.

3 Who should get Tdap vaccine and when?

Adolescents 11 through 18 years of age should get one booster dose of Tdap.

- A dose of Tdap is recommended for **adolescents who got DTaP or DTP as children** but have not yet gotten a dose of Td. The preferred age is 11-12.
- **Adolescents who have already gotten a booster dose of Td** are encouraged to get a dose of Tdap as well, for protection against pertussis. Waiting at least 5 years between Td and Tdap is encouraged, but not required.
- **Adolescents who did not get all their scheduled doses of DTaP or DTP** as children should complete the series using a combination of Td and Tdap.

Adults 19 through 64 years of age should substitute Tdap for **one** booster dose of Td. Td should be used for later booster doses.

- **Adults who expect to have close contact with an infant** younger than 12 months of age should get a dose of Tdap. Waiting at least 2 years since the last dose of Td is suggested, but not required.
- **Healthcare workers who have direct patient contact** in hospitals or clinics should get a dose of Tdap. A 2-year interval since the last Td is suggested, but not required.

An adolescent or adult who gets a severe cut or burn might need protection against tetanus infection. Tdap may be used if the person has not had a previous dose.

> **Td should be used rather than Tdap** if Tdap is not available, and for:
> - Anybody who has already gotten Tdap,
> - Adults 65 years of age and older,
> - Children 7 through 9 years of age.

If vaccination is needed during **pregnancy,** Td usually is preferred over Tdap. Ask your doctor. **New mothers** who have never received a dose of Tdap should get a dose as soon as possible after delivery.

Tdap may be given at the same time as other vaccines.

4 Some people should not get Tdap vaccine or should wait.

- Anyone who has had a **life-threatening allergic reaction** after a dose of DTP, DTaP, DT, or Td vaccine should not get Tdap.
- Anyone who has a **severe allergy to any component of the vaccine** should not get Tdap. Tell your health care provider if the person getting the vaccine has any known severe allergies.

continued . . .

- If the person getting the vaccine has a **severe allergy to latex**. Some Tdap vaccines should not be given to people with a severe latex allergy.
- Anyone who went into a **coma** or had a **long seizure** within 7 days after a dose of DTP or DTaP should not get Tdap, unless a cause other than the vaccine was found.
- Talk to your doctor if the person getting the vaccine:
  - has **epilepsy** or another **nervous system problem,**
  - had **severe swelling or severe pain** after a previous dose of any vaccine containing tetanus, diphtheria or pertussis,
  - has had **Guillain Barré Syndrome** (GBS).

Anyone who has a **moderate or severe illness** on the day the shot is scheduled should usually wait until they recover before getting the vaccine. Those with a mild illness or low fever can usually be vaccinated.

5 What are the risks from Tdap vaccine?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. However, the risk of a vaccine causing serious harm, or death, is extremely small.

If rare reactions occur with any new product, they may not be identified until many thousands, or even millions, of people have used the product. Like all vaccines, Tdap is being closely monitored for unusual or severe problems.

Clinical trials (testing before the vaccine was licensed) involved about 4,200 adolescents and about 1,800 adults. The following problems were reported. These are similar to problems reported after Td vaccine.

Mild Problems
(Noticeable, but did not interfere with activities)

- Pain (about 3 in 4 adolescents and 2 in 3 adults)
- Redness or swelling (about 1 in 5)
- Mild fever of at least 100.4°F (up to about 1 in 25 adolescents and 1 in 100 adults)
- Headache (about 4 in 10 adolescents and 3 in 10 adults)
- Tiredness (about 1 in 3 adolescents and 1 in 4 adults)
- Nausea, vomiting, diarrhea, stomach ache (up to 1 in 4 adolescents and 1 in 10 adults)
- Other mild problems reported include chills, body aches, sore joints, rash, and swollen lymph glands.

Moderate Problems
(Interfered with activities, but did not require medical attention)

Pain at the injection site (about 1 in 20 adolescents and 1 in 100 adults)

- Redness or swelling (up to about 1 in 16 adolescents and 1 in 25 adults)
- Fever over 102°F (about 1 in 100 adolescents and 1 in 250 adults)
- Nausea, vomiting, diarrhea, stomach ache (up to 3 in 100 adolescents and 1 in 100 adults)
- Headache (1 in 300)

Severe Problems
(Unable to perform usual activities; required medical attention)

- None were seen among adolescents.
- In the adult clinical trial, two adults had nervous system problems after getting the vaccine. These may or may not have been caused by the vaccine. They went away on their own and did not cause any permanent harm.
- A severe allergic reaction could occur after any vaccine. They are estimated to occur less than once in a million doses.

A person who gets these diseases is much more likely to have severe complications than a person who gets Tdap vaccine.

6 What if there is a severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

  VAERS does not provide medical advice.

7 The National Vaccine Injury Compensation Program

In the event that you or your child has a serious reaction to a vaccine, a federal program has been created to help pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call **1-800-338-2382** or visit their website at **www.hrsa.gov/vaccinecompensation.**

8 How can I learn more?

- Ask your immunization provider. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit CDC's National Immunization Program website at **www.cdc.gov/vaccines**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR IMMUNIZATION AND RESPIRATORY DISEASES

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Attachment H: Mandated Forms

Texas Department of State Health Services

Addendum to Tetanus, Diphtheria, and Pertussis (Tdap) Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: ☐ Tdap

Information about person to receive vaccine (Please print)

Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one) M F
Address: Street	City	County	State TX	Zip

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

x _____ Date _____

_____ Date _____
Witness

For Clinic/Office Use

Clinic/Office Address:

Date Vaccine Administered:

Vaccine Manufacturer:

Vaccine Lot Number:

Site of Administration:

Signature of Vaccine Administrator:

Title of Vaccine Administrator:

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Texas Department of State Health Services
EC-109 (07/06)

CDC InterimVIS Revision 07/12/06

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Attachment: Mandated Forms

TYPHOID VACCINE

WHAT YOU NEED TO KNOW

1 What is typhoid?

Typhoid (typhoid fever) is a serious disease. It is caused by bacteria called *Salmonella* Typhi.

Typhoid causes a high fever, weakness, stomach pains, headache, loss of appetite, and sometimes a rash. If it is not treated, it can kill up to 30% of people who get it.

Some people who get typhoid become "carriers," who can spread the disease to others.

Generally, people get typhoid from contaminated food or water. Typhoid is not common in the U.S., and most U.S. citizens who get the disease get it while traveling. Typhoid strikes about 21 million people a year around the world and kills about 200,000.

Typhoid vaccine can prevent typhoid.

2 Typhoid vaccines

There are two vaccines to prevent typhoid. One is an inactivated (killed) vaccine gotten as a shot, and the other is live, attenuated (weakened) vaccine which is taken orally (by mouth).

3 Who should get typhoid vaccine and when?

Routine typhoid vaccination is not recommended in the United States, but typhoid vaccine is recommended for:

- Travelers to parts of the world where typhoid is common. (NOTE: typhoid vaccine is not 100% effective and is not a substitute for being careful about what you eat or drink.)
- People in close contact with a typhoid carrier.
- Laboratory workers who work with *Salmonella* Typhi bacteria.

Inactivated Typhoid Vaccine (Shot)

- Should not be given to children younger than 2 years of age.
- One dose provides protection. It should be given at least 2 weeks before travel to allow the vaccine time to work.
- A booster dose is needed every 2 years for people who remain at risk.

Live Typhoid Vaccine (Oral)

- Should not be given to children younger than 6 years of age.
- Four doses, given 2 days apart, are needed for protection. The last dose should be given at least 1 week before travel to allow the vaccine time to work.
- A booster dose is needed every 5 years for people who remain at risk.

Either vaccine may be given at the same time as other vaccines.

4 Some people should not get typhoid vaccine or should wait

Inactivated Typhoid Vaccine (Shot)

- Anyone who has had a severe reaction to a previous dose of this vaccine should not get another dose.

Over . . .

Live Typhoid Vaccine (Oral)

- Anyone who has had a severe reaction to a previous dose of this vaccine should not get another dose.
- Anyone whose immune system is weakened should not get this vaccine. They should get the inactivated typhoid vaccine instead. These people include anyone who:
  - Has HIV/AIDS or another disease that affects the immune system.
  - Is being treated with drugs that affect the immune system, such as steroids, for 2 weeks or longer.
  - Has any kind of cancer.
  - Is taking cancer treatment with x-rays or drugs.
- Oral typhoid vaccine should not be given within 24 hours of certain antibiotics.

Ask your doctor or nurse for more information.

5 What are the risks from typhoid vaccine?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small. Serious problems from either of the two typhoid vaccines are very rare.

Inactivated Typhoid Vaccine (Shot)

Mild Reactions

- Fever (up to about 1 person per 100).
- Headache (up to about 3 people per 100).
- Redness or swelling at the site of the injection (up to 7 people per 100).

Live Typhoid Vaccine (Oral)

Mild Reactions

- Fever or headache (up to about 5 people per 100).
- Abdominal discomfort, nausea, vomiting, or rash (rare).

6 What if there is a moderate or severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS web site at www.vaers.org, or by calling 1-800-822-7967.

  VAERS does not provide medical advice.

7 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Visit CDC's typhoid website at **www.cdc.gov/ncidod/dbmd/diseaseinfo/typhoidfever_g.htm**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL IMMUNIZATION PROGRAM

CHICKENPOX VACCINE

WHAT YOU NEED TO KNOW

1 Why get vaccinated?

Chickenpox (also called varicella) is a common childhood disease. It is usually mild, but it can be serious, especially in young infants and adults.

- It causes a rash, itching, fever, and tiredness.
- It can lead to severe skin infection, scars, pneumonia, brain damage, or death.
- The chickenpox virus can be spread from person to person through the air, or by contact with fluid from chickenpox blisters.
- A person who has had chickenpox can get a painful rash called shingles years later.
- Before the vaccine, about 11,000 people were hospitalized for chickenpox each year in the United States.
- Before the vaccine, about 100 people died each year as a result of chickenpox in the United States.

Chickenpox vaccine can prevent chickenpox.

Most people who get chickenpox vaccine will not get chickenpox. But if someone who has been vaccinated does get chickenpox, it is usually very mild. They will have fewer blisters, are less likely to have a fever, and will recover faster.

2 Who should get chickenpox vaccine and when?

Routine

Children who have never had chickenpox should get 2 doses of chickenpox vaccine at these ages:

1st Dose: 12-15 months of age

2nd Dose: 4-6 years of age (may be given earlier, if at least 3 months after the 1st dose)

People 13 years of age and older (who have never had chickenpox or received chickenpox vaccine) should get two doses at least 28 days apart.

Catch-Up

Children or adolescents who are not fully vaccinated should receive one or two doses of chickenpox vaccine. The timing of these doses depends on the person's age. Ask your provider.

Chickenpox vaccine may be given at the same time as other vaccines.

> Note: Chickenpox vaccine may be given along with measles-mumps-rubella (MMR) vaccine in a combination vaccine called MMRV.

3 Some people should not get chickenpox vaccine or should wait

- People should not get chickenpox vaccine if they have ever had a life-threatening allergic reaction to gelatin, the antibiotic neomycin, or a previous dose of chickenpox vaccine.
- People who are moderately or severely ill at the time the shot is scheduled should usually wait until they recover before getting chickenpox vaccine.
- Pregnant women should wait to get chickenpox vaccine until after they have given birth. Women should not get pregnant for 1 month after getting chickenpox vaccine.
- Some people should check with their doctor about whether they should get chickenpox vaccine, including anyone who:
  - Has HIV/AIDS or another disease that affects the immune system
  - Is being treated with drugs that affect the immune system, such as steroids, for 2 weeks or longer
  - Has any kind of cancer
  - Is getting cancer treatment with radiation or drugs
- People who recently had a transfusion or were given other blood products should ask their doctor when they may get chickenpox vaccine.

Ask your doctor or nurse for more information.

4 What are the risks from chickenpox vaccine?

Getting chickenpox vaccine is much safer than getting chickenpox disease. Most people who get chickenpox vaccine do not have any problems with it.

However, a vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of chickenpox vaccine causing serious harm, or death, is extremely small.

Mild Problems

- Soreness or swelling where the shot was given (about 1 out of 5 children and up to 1 out of 3 adolescents and adults)
- Fever (1 person out of 10, or less)
- Mild rash, up to a month after vaccination (1 person out of 20, or less). It is possible for these people to infect other members of their household, but this is extremely rare.

> Note: MMRV vaccine has been associated with higher rates of fever (up to about 1 person in 5) and measles-like rash (about 1 person in 20) than MMR and varicella vaccines given separately.

Moderate Problems

- Seizure (jerking or staring) caused by fever (less than 1 person out of 1,000).

Severe Problems

- Pneumonia (very rare)

Other serious problems, including severe brain reactions and low blood count, have been reported after chickenpox vaccination. These happen so rarely experts cannot tell whether they are caused by the vaccine or not. If they are, it is extremely rare.

5 What if there is a moderate or severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarse ness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.
  Or you can file this report through the VAERS website at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

  VAERS does not provide medical advice.

6 The National Vaccine Injury Compensation Program

A federal program has been created to help people who may have been harmed by a vaccine.

For details about the National Vaccine Injury Compensation Program, call **1-800-338-2382** or visit their website at **www.hrsa.gov/vaccinecompensation**.

7 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit CDC website at: **www.cdc.gov/nip**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

DOCUMENT USED IN : CC IMMUNIZATIONS CLINIC

Attachment H: Mandated Forms

Texas Department of State Health Services

Addendum to Chickenpox Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: ☐ Chickenpox Vaccine

Information about person to receive vaccine (Please print)

Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one) M F

Address: Street	City	County	State	Zip
			TX	

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

x _____ Date _____

_____ Date _____
Witness

For Clinic/Office Use

Clinic/Office Address:

Date Vaccine Administered:

Vaccine Manufacturer:

Vaccine Lot Number:

Site of Injection:

Signature of Vaccine Administrator:

Title of Vaccine Administrator:

PRIVACY NOTIFICATION - With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA Privacy Notice.

Notice: Alterations or changes to this publication is prohibited without the express written consent of the Texas Department of State Health Services, Immunization Branch.

Instructions: File this consent statement in the patient's chart.

Texas Department of State Health Services
EC-97 (01/07)

CDC VIS Interim Revision 01/10/07

YELLOW FEVER VACCINE

WHAT YOU NEED TO KNOW

1 What is yellow fever?

Yellow fever is a serious disease caused by the yellow fever virus. It is spread through the bite of an infected mosquito and **cannot** be spread directly from person to person. It is found in certain parts of Africa and South America.

Yellow fever can cause:
- fever and flu-like illness
- jaundice (yellow skin or eyes)
- liver, kidney, respiratory and other organ system failure
- vomiting blood
- death

People with yellow fever disease usually have to be hospitalized.

2 How can I prevent yellow fever?

Yellow Fever Vaccine

Yellow fever vaccine can prevent yellow fever.

Yellow fever vaccine is given only at approved vaccination centers.

After receiving the vaccine, you should receive an **International Certificate of Vaccination** (yellow card) that has been validated by the vaccination center. This Certificate becomes valid 10 days after vaccination and lasts for 10 years. You will need this card as proof of vaccination to enter certain countries. Consult your health department or visit CDC's travel information website at http://www.cdc.gov/travel to learn the travel requirements for different countries or to find the nearest approved vaccination center.

Please make sure you discuss your travel itinerary with your doctor or nurse before you receive your yellow fever vaccination.

Other Preventive Measures

As with any disease transmitted by mosquitoes, precautions and insect repellent are also recommended to prevent exposure to yellow fever virus. These precautions include remaining in well-screened areas, wearing clothes that cover most of the body, and using effective insect repellent (i.e., containing up to 50% N,N-diethylmetatoluamide [DEET]) on skin and clothing.

3 Who should get yellow fever vaccine?

- Persons 9 months of age or older traveling to or living in a country that requires yellow fever vaccination for certain travelers. ***Check with your health-care provider.***
- Persons 9 months of age or older traveling to a country that does **not** require yellow fever vaccination but is located in an area where the risk of yellow fever is known to exist. ***Check with your health-care provider.***

Information about known or probable infected areas is available from the World Health Organization (http://www.who.int), the Pan American Health Organization (http://www.paho.org), and CDC (http://www.cdc.gov/travel).

If you continue to live or travel in yellow fever-endemic areas, you should receive a booster dose of yellow fever vaccine after 10 years.

Yellow fever vaccine may be given at the same time as most other vaccines.

4 Who should NOT get yellow fever vaccine?

- Persons who have ever had a life-threatening allergic reaction to eggs, chicken, gelatin or to a previous yellow fever vaccine.
- Infants younger than 9 months of age. For infants 6 to 8 months of age who cannot avoid travel to a yellow fever area, discuss vaccination with their doctor. Under no circumstances should infants younger than 6 months of age be vaccinated.
- Pregnant women and nursing mothers should avoid or postpone travel to a yellow fever area. If travel cannot be avoided, discuss vaccination with your doctor.

- Check with your doctor before getting yellow fever vaccine if:
  - You have a history of allergy to eggs, chicken, or gelatin
  - You have HIV/AIDS or another disease that affects the immune system
  - You have been under treatment for 2 weeks or longer with drugs that affect the immune system, such as steroids
  - You have any kind of cancer
  - You are taking cancer treatment with X-rays or drugs
  - Your thymus gland has been removed, or if you have a history of problems with your thymus, such as myasthenia gravis, DiGeorge syndrome, or thymoma.

If you are 65 or older, discuss with your physician the risks and benefits of vaccination in the context of your risk for exposure to yellow fever virus based on your destination.

If you cannot get the vaccine because of a medical reason and proof of yellow fever vaccination is required for your travel, your doctor can give you a waiver letter. When planning to use a waiver letter, you should also obtain specific advice from the embassy of the country or countries you plan to visit.

If you cannot get the vaccine, discuss with your doctor other ways to prevent yellow fever.

5 What are the risks from yellow fever vaccine?

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small.

Reactions are less likely to occur after a booster dose of yellow fever vaccine than after the first dose.

Mild problems:
- soreness, redness, or swelling where the shot was given
- fever
- aches

If these problems occur, they usually begin soon after the shot and last for 5-10 days. In studies, they occurred in as many as 25% of vaccine recipients.

Severe problems (estimates based on passive reporting)**:**
- Life-threatening allergic reaction (approximately 1 reported per 131,000 doses).
- Severe nervous system reactions (approximately 1 reported per 150,000-250,000 doses).
- Life-threatening severe illness with major organ system failure (approximately 1 reported per 200,000-300,000 doses, or 1 reported per 40,000-50,000 doses in people 60 years of age and older). More than half of the people who suffer these side effects die.

6 What if there is a moderate or severe reaction?

What should I look for?
- Look for any unusual condition, such as a high fever, behavior changes, or flu-like symptoms that occur 1-30 days after vaccination. Signs of an allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness within a few minutes to a few hours after the shot.

What should I do?
- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** the clinic where you received the vaccine to save any left over vaccine and the vaccine vial, and record the lot number.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.
  Or you can file this report through the VAERS website at www.vaers.org, or by calling 1-800-822-7967.
  VAERS does not provide medical advice.

7 How can I learn more?

- Ask your doctor or nurse. They can show you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Visit the CDC Travelers' Health website at www.cdc.gov/travel/diseases/yellowfever.htm, or other CDC websites at www.cdc.gov/ncidod/dvbid/yellowfever/, or http://www.cdc.gov/mmwr/preview/mmwrhtml/00031094.htm.

U.S. Department of Health & Human Services
Centers for Disease Control and Prevention
National Immunization Program

DOCUMENT USED IN : CC TUBERCULOSIS CLINIC

Texas Department of Health
Tuberculosis Elimination Division
Attachment H: Mandated Forms
Report of Case and Patient Services

Date reported to health department ___/___/___
Date form sent to region ___/___/___
Date form sent to central office ___/___/___

☐ Initial Report ☐ Hospital Admission
☐ Address Change ☐ Name Change (show new name and draw single line through old) ☐ Other Change (please circle)

SSN _____ Medicaid # _____ ID# _____ DOB ___/___/___ (MM DD YY)

Name _____ (Last) (First) (Middle) AKA _____

Street Apt# City County Zip Code Patient's Tel.#

Facility/Care Provider Name _____

Initial Reporting Source ☐ Health Dept ☐ Private Physician ☐ Public Hospital ☐ VA Hospital ☐ Military Hospital ☐ TDCJ ☐ Other (Specify) _____ Name of person completing this form

Country of Birth _____
If foreign born,
Date of entry into U.S. ___/___/___
Preferred Language _____

Notice of Arrival of Alien with TB Class
☐ A ☐ B1
☐ B2 ☐ B3

Reported at Death
☐ Yes ☐ No
If yes,
Death Date ___/___/___
Was TB cause of death
☐ Yes ☐ No ☐ Unk

Reported Out of State or Country
☐ Yes Specify _____ ☐ No

ETHNICITY ☐ Unknown
☐ Hispanic or Latino
☐ Not Hispanic or Latino

SEX
☐ Male
☐ Female

RACE (check all that apply)
☐ White
☐ Black or African American
☐ Asian
☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaskan Native
☐ Unknown

OCCUPATION (within past 2 years)
☐ Unemployed during last 2 yrs ☐ Unknown
☐ Employed (If employed, check all that apply)
☐ Migrant/Seasonal Worker
☐ Health Care Worker (Specify) _____
☐ Correctional Emp ☐ Other Occupation
☐ Other
☐ Student ☐ Child
☐ Retiree ☐ Disabled
☐ Homemaker
☐ Institutionalized

Resident of Correctional Facility at Time of Dx ☐ Yes ☐ No ☐ Unknown Incarceration Date ___/___/___
If Yes ☐ Federal Prison ☐ State Prison ☐ County Jail ☐ City Jail ☐ Juvenile Correctional Facility ☐ ICE ☐ Other

Resident of Long Term Care Facility at Time of Dx ☐ Yes ☐ No ☐ Unknown
If Yes ☐ Nursing Home ☐ Hospital-Based Facility ☐ Residential Facility ☐ Mental Health Residential Facility
☐ Alcohol/Drug Treatment Facility ☐ Other Long Term Care Facility

Screening activities to find latent TB infections
☐ Patient referred, TB infection ☐ Project targeted testing ☐ Individual targeted testing ☐ Administrative: Not at risk for TB

POPULATION RISKS
☐ Low Income
☐ Inner-city resident
☐ Foreign born
☐ Binational (US-Mexico)
*Within past 2 years
☐ Correctional employee*
☐ Health care worker*
☐ Prison/Jail inmate*
☐ Long-term facility for elderly/resident*
☐ Health care facility/resident*
☐ Shelter for homeless persons*
☐ Migrant farm worker*
☐ None of the above risks apply

MEDICAL RISKS
☐ Diabetes mellitus
☐ Alcohol Abuse (within past year)
☐ Tobacco use _____
☐ Silicosis
☐ Corticosteroids or other immunosuppressive therapy
☐ Gastrectomy or jejunoileal bypass
☐ age ≤ 5 years
☐ Recent exposure to TB (Contact to TB case)
☐ Contact to MDR-TB case
☐ Weight at least 10% less than ideal body weight
☐ Chronic malabsorption syndromes
☐ Leukemia
☐ Lymphoma
☐ Cancer of head
☐ Cancer of neck
☐ Drug abuse within past year:
☐ Injecting
☐ Non-injecting
☐ Unknown if injecting
☐ HIV seropositive (check only if laboratory confirmed)
☐ Tuberculin skin test conversion within 2 years
☐ Fibrotic lesions (on chest x-ray) consistent with old, healed TB
☐ Chronic renal failure
☐ Organ Transplant
☐ Other _____
☐ None of these medical risks apply

HIV TEST RESULTS
Date HIV Test ___/___/___
☐ Positive ☐ Negative
☐ Pending ☐ Refused
☐ Not Offered

Date CD4 Count ___/___/___
Results CD4 Count _____

TUBERCULIN SKIN TEST Documented history of positive TST? ☐ Yes ☐ No

___/___/___ ____ mm ☐ Positive ☐ Negative ☐ Not Read
___/___/___ ____ mm ☐ Positive ☐ Negative ☐ Not Read

PRIOR LTBI TREATMENT ☐ Yes ☐ No
Start Date ___/___/___
Stop Date ___/___/___

FOR TREATMENT OF LTBI ONLY

___/___/___ Date Normal Chest X-ray Weight _____ Height _____

DOPT: ☐ Yes, totally observed ☐ No, self-administered ☐ Both
DOPT Site: ☐ Clinic or medical facility ☐ Field ☐ Both
Frequency: ☐ Daily ☐ Twice Weekly ☐ Three X's Weekly

ATS Classification
☐ 0 No M. TB Exposure, Not TB Infected
☐ 1 M. TB Exposure, No Evidence of TB Infection
☐ 2 M. TB Infection, No Disease
☐ 4 M. TB, No Current Disease

___/___/___ Date Regimen Start ___/___/___ Date Regimen Stop

___/___/___ Date Restart ___/___/___ Date Regimen Stop

☐ Isoniazid ____ mgs ☐ Other (specify) _____ ____ mgs
☐ Rifampin ____ mgs ☐ Other (specify) _____ ____ mgs
☐ B6 ____ mgs Prescribed for: ____ months Maximum refills authorized: ____ Physician Signature Date

CLOSURE: Date ___/___/___ ☐ Completion adequate therapy ____ # months on Rx ____ # months recommended
☐ Lost to followup ☐ Patient chose to stop ☐ Deceased (Cause) _____
☐ Adverse Drug Reaction ☐ Moved out of state/country to: _____
Provider decision: ☐ Pregnant ☐ Non-TB ☐ Other: _____

ProtectTexas™ Texas Department of Health
TB-400A (11/03)

DOCUMENT USED IN : CC TUBERCULOSIS CLINIC

Texas Department of State Health Services
Report of Tuberculosis Case and Patient Services

Attachment H: Mandated Forms

Date reported to health department ___/___/___
Date form sent to region ___/___/___
Date form sent to central office ___/___/___

☐ Initial Report ☐ Drug Resistance ☐ Followup or Medical Review ☐ Hospital Admission or Discharge

Name _____ DOB ___/___/___
(Last) (First) (Middle) MM DD YY

_____ SSN _____
Street Apt# City County Zip Code

Facility/Care Provider Name _____ _____
Facility responsible for patient care ☐ Public Health Clinic ☐ Private Physician ☐ Hospital ☐ Other (Specifiy) _____ *Name of person completing this form*

Signs/Symptoms at DX

Fever	☐ Y	☐ N
Chills	☐ Y	☐ N
Cough	☐ Y	☐ N
Productive Cough	☐ Y	☐ N
Hemoptysis	☐ Y	☐ N
Night Sweats	☐ Y	☐ N
Weight Loss (≥ 10%)	☐ Y	☐ N

Other:

Chest X-Ray
Date ___/___/___
Results: ☐ Normal ☐ Abnormal ☐ Not Done ☐ Unk
If Abnormal, check abnormality
☐ Cavitary
☐ Non-cavitary, consistent with TB
☐ Non-cavitary, not consistent with TB
Comments:

Status
☐ Stable
☐ Worsening
☐ Improving
☐ Unknown

If Pediatric TB Case (<15 Years Old)
Country of birth for primary guardians:
Guardian 1) _____
Guardian 2) _____
Patient lived outside US for > 3 months
☐ Yes ☐ No ☐ Unknown
If yes,
Country _____

Status ☐ New ☐ Recurrent ☐ Reopen
Prior Therapy ☐ Yes ☐ No Start Date ___/___/___
Stop Date ___/___/___

ATS Classification
☐ 0 No M. TB Exposure, Not TB Infected
☐ 1 M. TB Exposure, No Evidence of TB Infection
☐ 2 M. TB Infection, No Disease
☐ 3 M. TB Infection, Current Disease
☐ 4 M. TB, No Current Disease
☐ 5 M. TB Suspect, Diagnosis Pending

Predominant Site: (Class 3, 4) _____
Significant Sites other than Predominant

00	☐ Pulmonary	30	☐ Bone and/or Joint
10	☐ Pleural	40	☐ Genitourinary
20	☐ Lymphatic	50	☐ Miliary/Disseminated
21	☐ Cervical	60	☐ Meningeal
22	☐ Intrathoracic	70	☐ Peritoneal
23	☐ Other	80	☐ Other(*Specify*)_____

Other Diagnosis

Treatment for Active TB Disease Weight _____ Height _____
Regimen Start ___/___/___ Regimen Stop ___/___/___
Restart ___/___/___ Stop ___/___/___
Directly Observed Therapy (DOT) Doses:
☐ Yes ☐ No If no, specify reason_____

DOT Site: ☐ Clinic or other medical facility ☐ Field ☐ Both
Frequency: ☐ Daily ☐ Twice Weekly ☐ Three X's Weekly

☐ Isoniazid	____ mgs	☐ Rifater	____ mgs
☐ Rifampin	____ mgs	☐ Levofloxacin	____ mgs
☐ Rifamate	____ mgs	☐ Gatifloxacin	____ mgs
☐ Pyrazinamide	____ mgs	☐ Moxifloxacin	____ mgs
☐ Ethambutol	____ mgs	☐ Rifapentine	____ mgs
☐ Streptomycin	____ mgs	☐ Clofazimine	____ mgs
☐ Ethionamide	____ mgs	☐ Cycloserine	____ mgs
☐ Capreomycin	____ mgs	☐ PAS	____ mgs
☐ Amikacin	____ mgs	☐ B6	____ mgs
☐ Ciprofloxacin	____ mgs	☐ _____	____ mgs
☐ Ofloxacin	____ mgs	☐ _____	____ mgs
☐ Rifabutin	____ mgs	☐ _____	____ mgs

Prescribed for:_____ months Maximum refills authorized:_____

Closure:
Date ___/___/___ ____ % doses taken by DOT
____ # doses taken ____ # doses recommended
____ # months on Rx ____ # months recommended
☐ Completion of adequate therapy ☐ Lost to followup
☐ Patient chose to stop ☐ Adverse drug reaction
☐ Deceased(Cause)_____
☐ Moved out of state/country to: _____
Date referral sent to Austin ___/___/___
Provider decision: ☐ Pregnant ☐ Non-TB ☐ Other:_____

AFB Smear Results
Current ___/___/___ ☐ Negative ☐ Positive ☐ Pending ☐ Not done
Specimen type: ☐ sputum ☐ urine ☐ bronchial washing ☐ biopsy ☐ other
If biopsy or other, list anatomic site of specimen:_____
If other than sputa, type of exam _____
Collection date of initial positive AFB smear: ___/___/___
Collection date of first consistently negative AFB smear:___/___/___

Nucleic Acid Amplification Test
Current ___/___/___ ☐ Negative ☐ Positive ☐ Indeterminate ☐ Not done

Culture Results
Current ___/___/___ ☐ Negative ☐ Positive for M. TB
☐ Positive for Non-M. TB _____ ☐ Pending ☐ Not done
Specimen type: ☐ sputum ☐ urine ☐ bronchial washing ☐ biopsy ☐ other
If biopsy or other, list anatomic site of specimen: _____
Collection date of initial positive MTB culture: ___/___/___
Collection date of first consistently negative MTB culture:___/___/___
Sputum culture conversion documented? ☐ Yes ☐ No ☐ NA
If no, then reason

Susceptibility Results
Date initial susceptibility culture was collected ___/___/___
Initial culture was resistant to: ☐ Isoniazid ☐ Rifampin ☐ Ethambutol
Date last positive culture was collected ___/___/___
Last culture was resistant to: ☐ Isoniazid ☐ Rifampin ☐ Ethambutol
☐ Other quinolone(s)_____
☐ Other(s)_____

Reason Therapy Extending > 12 months: _____
Hospitalization Advised: ☐ Yes ☐ No Control Order ___/___/___
Quarantine Advised: ☐ Yes ☐ No Court Action ___/___/___
Return for chest x-ray: ___/___/___ Compliant: ☐Yes ☐ No
Collect next sputum on: ___/___/___ Other lab studies:___/___/___
Return to MD clinic on: ___/___/___
Return to Nurse clinic on:___/___/___

_____
Nurse Signature Date

_____
Physician Signature Date
____ Authorize nurse to obtain informed consent
General Comments:

TEXAS Department of State Health Services
TB-400B (6/05)

TDH

TUBERCULOSIS ELIMINATION DIVISION

REPORT OF CONTACTS

Date __/__/____

A. Case/Suspect Information

Last Name	First Name	Middle Name	DOB	SSN	Sex	Race	Ethnicity
			__/__/____	___-__-____	☐ M ☐ F	☐ White ☐ Black ☐ Asian/Pac. ☐ American Indian/Alaskan	☐ Hispanic ☐ Non-Hispanic

Street Address | Apt. | City | County | Zip Code | Census Tract | Phone: | Other:

Status: New case | Recurrent | Suspect | Reopen

Predominant Site: Pulmonary | Laryngeal | Other_____

Is case married? ☐ Yes ☐ No

Daycare center attendee/employee? ☐ Yes ☐ No

Onset of Symptoms: __/__/____

TST Date __/__/____ mm _____ Positive ☐ Yes ☐ No

RX Started: __/__/____

CXR Date __/__/____ Reading _____ Cavitary ☐ Yes ☐ No

Compliant with therapy: ☐ Yes ☐ No

Source case: _____ Last Name | First | Middle

Date no longer infectious: __/__/____

Bacteriology

Specimen	Collection Date	Smear	Culture	ID	Resistant to:

Comments:

Duplicate contacts to:

No contacts identified due to:

B. Interview Information

Date case/suspect reported: __/__/____

Interviewer: _____ Last Name _____ First Name

Interview date: __/__/____

Clinic:

C. Contact Information

Last Name | First | Middle

Address

City | County | Country

Telephone No. | Home | Work

Other

SSN ___-__-____

Sex ☐ Male ☐ Female

Race _____ ☐ Hisp ☐ Non-Hisp

DOB __/__/____

BCG ☐ Yes ☐ No

__/__/____

Relation to case:

Exp. Risk: ☐ Close ☐ Casual ☐ No contact was made

Exp. Site: ☐ Household ☐ Work site ☐ Other

Date contact broken __/__/____

History of positive TST? ☐ Yes ☐ No

TST Date

__/__/____ ___mm

__/__/____ ___mm

__/__/____ ___mm

TST positive: ☐ Yes ☐ No

CXR date __/__/____ ☐ norm. ☐ abn.

HIV Test Results ☐ Positive ☐ Negative ☐ UNK

Treatment and Disposition

Treatment Started: __/__/____

Treatment Stopped: __/__/____

Number of months:

Recommended _____

Taken _____

Clinic:

☐ TB disease
☐ Treatment not started
☐ Completed treatment
☐ Contact chose to stop
☐ Lost to follow-up
☐ Active TB developed
☐ Provider decision
☐ Contact moved follow-up UNK
☐ Death
☐ Adverse drug reaction

Name | First | Middle

ess

County | Country

hone No. | Home | Work

SSN ___-__-____

Sex ☐ Male ☐ Female

Race _____ ☐ Hisp ☐ Non-Hisp

DOB __/__/____

BCG ☐ Yes ☐ No

__/__/____

Relation to case:

Exp. Risk: ☐ Close ☐ Casual ☐ No contact was made

Exp. Site: ☐ Household ☐ Work site ☐ Other

Date contact broken __/__/____

History of positive TST? ☐ Yes ☐ No

TST Date

__/__/____ ___mm

__/__/____ ___mm

__/__/____ ___mm

TST positive: ☐ Yes ☐ No

CXR date __/__/____ ☐ norm. ☐ abn.

HIV Test Results ☐ Positive ☐ Negative ☐ UNK

Treatment Started: __/__/____

Treatment Stopped: __/__/____

Number of months:

Recommended _____

Taken _____

Clinic:

☐ TB disease
☐ Treatment not started
☐ Completed treatment
☐ Contact chose to stop
☐ Lost to follow-up
☐ Active TB developed
☐ Provider decision
☐ Contact moved follow-up UNK
☐ Death
☐ Adverse drug reaction

TB-340 (8/2000)

Attachment H: Mandated Forms

Collin County

DOCUMENT USED IN : CC TUBERCULOSIS CLINIC

TDH

CONTINUATION OF REPORT OF CONTACTS

Page ____ of ____ Date __ __/__ __ __ __

Case Name	Date of Birth	SSN

Case Name		Date of Birth		SSN
Last Name First Middle Address City County Country Telephone No. Home Work Other	SSN __ __ __-__ __-__ __ __ __ Sex ☐ Male ☐ Female Race _____ ☐ Hisp ☐ Non-Hisp DOB __ __/__ __/__ __ __ __ BCG ☐ Yes ☐ No __ __/__ __/__ __ __ __ Relation to case:	Exp. Risk: ☐ Close ☐ Casual ☐ No contact was made Exp. Site: ☐ Household ☐ Work site ☐ Other Date contact broken __ __/__ __/__ __ __ __	History of positive TST? ☐ Yes ☐ No TST Date __ __/__ __/__ __ __ __ ____mm __ __/__ __/__ __ __ __ ____mm __ __/__ __/__ __ __ __ ____mm TST positive: ☐ Yes ☐ No CXR date __ __/__ __/__ __ __ __ ☐ norm. ☐ abn. HIV Test Results ☐ Positive ☐ Negative ☐ UNK	Treatment and Disposition Treatment Started: __ __/__ __/__ __ __ __ Treatment Stopped: __ __/__ __/__ __ __ __ Number of months: Recommended _____ Taken _____ Clinic: ☐ TB disease ☐ Treatment not started ☐ Completed treatment ☐ Contact chose to stop ☐ Lost to follow-up ☐ Active TB developed ☐ Provider decision ☐ Contact moved follow-up UNK ☐ Death ☐ Adverse drug reaction
Last Name First Middle Address City County Country Telephone No. Home Work Other	SSN __ __ __-__ __-__ __ __ __ Sex ☐ Male ☐ Female Race _____ ☐ Hisp ☐ Non-Hisp DOB __ __/__ __/__ __ __ __ BCG ☐ Yes ☐ No __ __/__ __/__ __ __ __ Relation to case:	Exp. Risk: ☐ Close ☐ Casual ☐ No contact was made Exp. Site: ☐ Household ☐ Work site ☐ Other Date contact broken __ __/__ __/__ __ __ __	History of positive TST? ☐ Yes ☐ No TST Date __ __/__ __/__ __ __ __ ____mm __ __/__ __/__ __ __ __ ____mm __ __/__ __/__ __ __ __ ____mm TST positive: ☐ Yes ☐ No CXR date __ __/__ __/__ __ __ __ ☐ norm. ☐ abn. HIV Test Results ☐ Positive ☐ Negative ☐ UNK	Treatment and Disposition Treatment Started: __ __/__ __/__ __ __ __ Treatment Stopped: __ __/__ __/__ __ __ __ Number of months: Recommended _____ Taken _____ Clinic: ☐ TB disease ☐ Treatment not started ☐ Completed treatment ☐ Contact chose to stop ☐ Lost to follow-up ☐ Active TB developed ☐ Provider decision ☐ Contact moved follow-up UNK ☐ Death ☐ Adverse drug reaction
Last Name First Middle Address City County Country Telephone No. Home Work Other	SSN __ __ __-__ __-__ __ __ __ Sex ☐ Male ☐ Female Race _____ ☐ Hisp ☐ Non-Hisp DOB __ __/__ __/__ __ __ __ BCG ☐ Yes ☐ No __ __/__ __/__ __ __ __ Relation to case:	Exp. Risk: ☐ Close ☐ Casual ☐ No contact was made Exp. Site: ☐ Household ☐ Work site ☐ Other Date contact broken __ __/__ __/__ __ __ __	History of positive TST? ☐ Yes ☐ No TST Date __ __/__ __/__ __ __ __ ____mm __ __/__ __/__ __ __ __ ____mm __ __/__ __/__ __ __ __ ____mm TST positive: ☐ Yes ☐ No CXR date __ __/__ __/__ __ __ __ ☐ norm. ☐ abn. HIV Test Results ☐ Positive ☐ Negative ☐ UNK	Treatment and Disposition Treatment Started: __ __/__ __/__ __ __ __ Treatment Stopped: __ __/__ __/__ __ __ __ Number of months: Recommended _____ Taken _____ Clinic: ☐ TB disease ☐ Treatment not started ☐ Completed treatment ☐ Contact chose to stop ☐ Lost to follow-up ☐ Active TB developed ☐ Provider decision ☐ Contact moved follow-up UNK ☐ Death ☐ Adverse drug reaction
Last Name First Middle Address City County Country Telephone No. Home Work Other	SSN __ __ __-__ __-__ __ __ __ Sex ☐ Male ☐ Female Race _____ ☐ Hisp ☐ Non-Hisp DOB __ __/__ __/__ __ __ __ BCG ☐ Yes ☐ No __ __/__ __/__ __ __ __ Relation to case:	Exp. Risk: ☐ Close ☐ Casual ☐ No contact was made Exp. Site: ☐ Household ☐ Work site ☐ Other Date contact broken __ __/__ __/__ __ __ __	History of positive TST? ☐ Yes ☐ No TST Date __ __/__ __/__ __ __ __ ____mm __ __/__ __/__ __ __ __ ____mm __ __/__ __/__ __ __ __ ____mm TST positive: ☐ Yes ☐ No CXR date __ __/__ __/__ __ __ __ ☐ norm. ☐ abn. HIV Test Results ☐ Positive ☐ Negative ☐ UNK	Treatment and Disposition Treatment Started: __ __/__ __/__ __ __ __ Treatment Stopped: __ __/__ __/__ __ __ __ Number of months: Recommended _____ Taken _____ Clinic: ☐ TB disease ☐ Treatment not started ☐ Completed treatment ☐ Contact chose to stop ☐ Lost to follow-up ☐ Active TB developed ☐ Provider decision ☐ Contact moved follow-up UNK ☐ Death ☐ Adverse drug reaction

COMMENTS:

Attachment H: Handed Form

Collin County

DOCUMENT USED IN : CC TUBERCULOSIS CLINIC

DOCUMENT USED IN : CC TUBERCULOSIS CLINIC

Attachment H: Mandated Forms

Texas Department of State Health Services
TB Case and Suspect Management Plan
RN Case Management Group Review

Patient's Name:_____ **Patient's DOB:** _____

Directions: Blank boxes indicate week(s) TB service is to be provided. ***Document date and initials of the provider in the appropriate box when the task is completed.*** Document comments in progress notes.

Action: / **Interval:**		**0 Begin**	**2 Wks**	**4 Wks**	**8 Wks**	**12 Wks**	**16 Wks**	**20 Wks**	**24 Wks**	**26 Wks**
Date		/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Responsibility	Group of all RN's in the TB clinic									
Medical Evaluation	Obtain medical history; document on TB-202									
	Obtain consent to release/ send records									
	MD evaluation									
	RN evaluation									
	Mantoux skin test (if not previously done)									
	Chest X-ray									
	Supervised sputum for AFB smear/culture according to protocol									
	HIV testing, unless patient has knowledge of HIV+ status or has documented negative HIV test result within 14 days of TB diagnosis									
	Nutritional assessment									
Treatment	Drug regimen according to protocol or specific order									
	Obtain Informed Consent form TB-411 (TB-411A, if Spanish speaking, only) initially and for any drugs added to regimen.									
Consultation	Obtain expert consult for drug resistant cases, complicated adult/pediatric cases or client who remains symptomatic or sputum positive after 2 months therapy; written consult in client record									
Toxicity/ Clinical Assessment	Clinical assessment according to protocol; document (TB-205 and progress note as appropriate)									
	Visual acuity (Snellen) and color discrimination (Ishihara Plates) initially and monthly if on EMB or rifabutin; document (TB-205)									
	Hearing sweep check initially and monthly if on amikacin, capreomycin, kanamycin or streptomycin; document (TB-205)									

TB-201 TB Case and Suspect Management Plan for Outpatient Care – 01/08 Amended by CCHC (Continued on Reverse)

TB Case and Suspect Management Plan for Outpatient Care

Attachment H: Mandated Forms

Action: / Interval:		0 Begin	2 Wks	4 Wks	8 Wks	12 Wks	16 Wks	20 Wks	24 Wks	26 Wks
Date		/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Adherence	Issue Order to Implement Measures for a Client With Tuberculosis form TB-410 (TB-410A, if Spanish speaking, only) on all cases/suspects									
	Follow-up missed appointments within 1 working day; initiate court-ordered management according to TDH policy (see TB Policy Manual, Section 5) and notify Regional office									
	Evaluate barriers to treatment									
Isolation	Conduct **site visit** to assess living situation.									
	Institute isolation in congregate living situation or home and exclude from work or school, if infectious									
	Discontinue congregate setting isolation or allow to return to work/school following at least 2 wks appropriate therapy, 3 consecutive negative smears on different days and an improvement of symptoms									
Education	Appropriate client education provided initially and monthly per protocol; written instructions and monthly review of medication side effects, document on TB-203									
Public Health/ Contact Investigation	Interview case/suspect and contacts; plan contact investigation using the "Concentric Circle" approach									
	Initiate contact investigation within 3 working days; interview and evaluate (skin test/reading, CXR, medical evaluation); document on TB-340									
	Expand contact investigation according to CDC guidelines and local criteria for expansion.									
	Provide second skin test 8-10 weeks after break in contact with the case to all contacts who were skin test negative on the initial test; document on TB-340									
	Provide education and counseling for contacts									
Reporting										
	Submit TB-400A and TB-400B (all data fields complete) within 7 days of diagnosis; submit TB-400B at least quarterly and at the time of closure									
	Submit TB-340 within 14 working days of initiating contact investigation and after second testing of negative contacts is complete									
Quality Assurance Review	Clinical supervisor or TB Program Manager reviews and evaluates contact investigation									
	Team review of client record									
Social Services	Provide low cost clinic and social services information as indicated.									

PRINTED NAME: Eva Best, RN, MS **SIGNATURE:**_____ **INITIALS:**_____

PRINTED NAME: Candice Akins, RN **SIGNATURE:**_____ **INITIALS:**_____

PRINTED NAME: Sheila Fassnacht, RN **SIGNATURE:**_____ **INITIALS:**_____

PRINTED NAME: Lorraine Marquez, CMA **SIGNATURE:**_____ **INITIALS:**_____

PRINTED NAME:_____ **SIGNATURE:**_____ **INITIALS:**_____

DOCUMENT USED IN : CC TUBERCULOSIS CLINIC

Attachment H: Mandated Forms

Texas Department of State Health Services
Tuberculosis Health Assessment/History

MEDICAID?
MEDICARE?
CARD COPIED _____
INFO TO PATSY_____

Patient Name: Last First Middle Birth Date Sex Race Ethnicity

Address: Street City County State Zip Census Tract Phone: Home / Work

Date of History: Primary Care Provider Phone Number of Primary Care Provider

MEDICAL HISTORY	+/-	COMMENTS		+/-	COMMENTS
Allergies			Leukemia		
Diabetes		Type 1___ Type 2 ___	Lymphoma		
Respiratory Problems (Levaquin or other antibiotic use?)			Cancer Head ____ Neck ____ Other		
Silicosis/Asbestosis			HIV/STD		If HIV+, CD4 count Date
Environmental Exposures			Chronic Renal Failure		
Corticosteroids (Received equivalent of >15 mg/d Prednisone for >1 mo)			Liver Disease/Hepatitis (Risk factors HepB/C: IDU, HIV+, or birth in Asia, Africa, or Amazon basin)		
Organ Transplant			Autoimmune		
GI/Gastrectomy or jejunoileal bypass			Arthritis/Gout		Use of Remicade, Humira or Enbrel?
Weight at least 10% less than ideal body weight			Chronic Malabsorption Syndrome		
Mental Illness/Retardation			Surgeries/Hospitalizations		
Skin Disease			Contraception/LMP		
Hypertension/CVA		Blood Pressure_____/_____	Gyn/Pregnancy		
Heart Disease/PVD			Breast Feeding		
Thyroid			Post Partum		
Neurological/Seizures			Other		
Vision/Hearing Disorder			Other		

MEDICATIONS TAKING, EXCLUDING TB DRUGS	START DATE	DOSAGE SCHEDULE	STOP DATE	PRESCRIBING PHYSICIAN

TUBERCULOSIS HISTORY	+/-	COMMENTS			
Live virus vaccine in last 6 wks		List:			
History Of BCG		Date(s):			
Prior PPD Skin Test		Date:	Result (mm):	Date:	Result (mm):
Prior Chest X-Ray		Date:	Result:		
Prior Treatment of TB		Date:	Location:		Length of Tx:
Prior Treatment of LTBI		Date:	Location:		Length of Tx:
Family History of TB		Date:	Relationship To Patient:		
Contact to TB case		Date:	Where?	Source Case?	
Contact to MDR-TB case		Date:	Where?	Source Case?	

+ = If History Is Positive - = If History Is Negative

TB-202 Tuberculosis Health Assessment/History – 01/08 (Continued on Reverse)

Tuberculosis Health Assessment/History

Attachment B: Mandated Forms

SIGNS & SYMPTOMS OF TB	+/-	DATE OF ONSET	COMMENTS
Cough (Persistent X3 Weeks)			
Weight Loss			Today's wt._____ Est. wt. 3 mo. ago _____
Fever / Chills			Today's temperature _____
Shortness of Breath			
Chest Pain			
Fatigue			
Loss of Appetite			
Night Sweats			
Hemoptysis			
Hoarseness			
Eye Pain or Blurry Vision			
Swelling of Lymph Node(s)			
Frequent Urination, Bloody Urine or Flank Pain			
Swelling of Joint / Vertebra			
Headache, Decreased Level of Consciousness or Neck Stiffness			
Pain / Swelling in Other Locations			

SOCIAL HISTORY	+/-	COMMENTS	
Tobacco use		_____ pks / day _____ years of use	**Education:** [ ] Elem. Sch. [ ] Jr. Hi. [ ] Hi. Sch. [ ] College
Alcohol		Current # alcoholic drinks per week	**Housing:** [ ] Own [ ] Rent [ ] Homeless [ ] Inner city resident [ ] Binational (US-Mexico) [ ] Low Income [ ] Live Alone [ ] Live With Others
HIV/AIDS Risk			**Long-Term Care:** [ ] Nsg. Home [ ] Hosp.-Based [ ] Residential [ ] Mental Health Res. [ ] Alcohol/Drug Treatment [ ] Other
Drug Abuse		____ Non-injecting Drugs? ____ Injecting Drugs?	**Incarceration:** [ ] Fed. Prison [ ] State Prison [ ] Local Jail [ ] ICE [ ] Juvenile Correctional [ ] Other Corr. [ ] Unknown. Incarceration date:
Malnutrition/Diet low in sources of B_6			**Occupation:** [ ] Health Care [ ] Correctional [ ] Migrant/Seasonal [ ] Other Occupation [ ] Not employed in past 24 mo [ ] Student [ ] Child [ ] Homemaker [ ] Retiree [ ] Institutionalized [ ] Unk
Foreign Birth		If foreign-born, Country Mo/Yr Entry US	**If Pediatric TB Case/Suspect (< 15 years old)** Country of birth for primary guardian(s) Patient lived outside US for > 3 months [ ] Yes. [ ] No If yes, country
Foreign Travel or Residence			**Locating Info:**
Barriers to Compliance			

ADDITIONAL COMMENTS

Signature of person taking history	Signature of interpreter (if used)

+ = If History Is Positive - = If History Is Negative

TB-202 Tuberculosis Health Assessment/History – 01/08

TEXAS Department of State Health Services

DOCUMENT USED IN : CC TUBERCULOSIS CLINIC

Texas Department of State Health Services
Clinical Assessment for Tuberculosis Medication Toxicity

Attachment H: Mandated Forms

NAME: _____ D.O.B.: ____/____/____ SS#: ____/____/____

Adverse Drug Reaction Assessment:
Ask questions (1-18) when patient is on first-line drugs and ask questions (1-28) if any second-line drugs are added to patient's regimen. Document [+] results in the progress notes and notify the physician. Notify physician if a woman of childbearing age indicates that she thinks she may be pregnant or has signs of pregnancy.
Results: [+] = If Present [-] = If Denies [NA] = If Not Applicable

	Date	Date	Date	Date	Date	Date	Date	Date	Date
Weight									
Temperature									
Blood Pressure									
Do you have any of the following symptoms now or since your last clinic appointment?									
1. Loss of Appetite									
2. Nausea/Vomiting									
3. Urine Color Change (Dark)									
4. Skin Rashes/Dry									
5. Numbness/Tingling (Hands/Feet, Face/Mouth)									
6. Change in Vision*									
7. Eye Pain/Irritation (Redness, Excessive Tears)									
8. Jaundice (Yellow Skin/Eyes)									
9. Flu-like Symptoms									
10. Fatigue									
11. Headaches									
12. Fever									
13. Joint Pains/Swelling									
14. Urine Output ↕									
5. Bleeding (Nose Bleeds, Hemoptysis)									
16. Vertigo/Dizziness/Fainting									
Teeter/Fall to Left or Right When Standing (With Eyes Closed)									
Weave/Stagger When Walking (Normal Gait)									
17. Hearing Loss/Ears Ringing/Fullness									
18. Nervousness/Giddiness/Restlessness									
19. Increased Gas/Stomach Cramps									
20. Abdominal Pain/Diarrhea									
21. Sleep Problems									
22. Mood Changes/Depression									
23. Change in Heart Rate									
24. Convulsions									
25. Memory Loss									
26. Abnormal Behavior									
27. Skin Discoloration									
28. Allergic Reaction									
Ask about use of over the counter medications such as Tylenol, etc.									
Ask women about signs of pregnancy.									

Drug Issued	Mfg/Lot#/Exp	Route/ Frequency	Amt. Given	Amt. Given	Amt. Given	Amt. Given	Amt. Given	Amt. Given	Amt. Given	Amt. Given	Amt. Given
Initials**/Title											
Interpreter											
Next Appt.											

* Changes in Vision may include blind spots in field of vision, blurred vision, changes in peripheral vision
** See Provider Signature Sheet

TEXAS Department of State Health Services

TB205-Clinical Assessment for TB Medication Toxicity (Continued on Reverse) Revised 2/08

DOCUMENT USED IN :
CC TUBERCULOSIS CLINIC

Texas Department of State Health Services

Attach/Hearing Mandated Forms

NAME: _____

Red/Green Color Discrimination:
The (X) mark indicates the plate cannot be read. Screen all 14 plates. Client must pass 10 of the first 11 plates for the test to be regarded as normal. Refer for evaluation if ≤ 7 plates are read as normal.
Results: [N] = Normal [A] = Abnormal

Ishihara Plate #	Normal Reading	Red/Green Deficiency				Date	Date	Date	Date	Date	Date	Date	Date	Date
1	12	12												
2	8	3												
3	5	2												
4	29	70												
5	74	21												
6	7	X												
7	45	X												
8	2	X												
9	X	2												
10	16	X												
11	Traceable	X												
		Protan		Deutan										
		Strong	Mild	Strong	Mild									
12	35	5	(3) 5	3	3 (5)									
13	96	6	(9) 6	9	9 (6)									
14	Can trace 2 lines	Purple	Purple (Red)	Red	Red (Purple)									
Results														
Initials														

Visual Acuity:
If initial screen was conducted with corrective lenses (glasses or contacts), follow-up screens must be done the same. A change of 1 or more lines from the initial screen in either one or both eyes must be reported to the physician immediately.
Results: [P] = Pass [F] = Fail [U] = Unscreenable **Chart Used:** [ ] Letter [ ] "E" [ ] Other, Specify:_____
Corrective Lenses: [ ] = Yes [ ] = No

Distance Acuity	Date	Date	Date	Date	Date	Date	Date	Date	Date
Right Eye	20/	20/	20/	20/	20/	20/	20/	20/	20/
Left Eye	20/	20/	20/	20/	20/	20/	20/	20/	20/
Both Eyes	20/	20/	20/	20/	20/	20/	20/	20/	20/
Results									
Initials									

Hearing Sweep Check:
When patient is taking amikacin, capreomycin, kanamycin, or streptomycin, for each of the four frequencies listed, record the lowest level in decibels (dB) at which the person responds. Record the findings for both the right and left ear. Refer to an appropriately licensed professional if any two of the four frequencies are recorded as greater than 25 dB in either ear or the same ear or if there is a change of decreased hearing level from baseline. Start with 40 dB, if heard decrease by 10 dB until no response is obtained or until 20 dB is reached. If 20 dB is heard, record as 20 dB. Once no response is obtained, increase the dB level by 5 until a response is obtained and recorded. If a response is not heard at 40 dB, record as 40+ dB.
Results: [P] = Pass [R] = Refer [O] = Observe **Ear:** [R] = Right [L] = Left

Frequency	Date		Date		Date		Date		Date		Date		Date		Date		Date	
Ear	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
500 Hz																		
1000 Hz																		
000 Hz																		
4000 Hz																		
Initials																		

TB205-Clinical Assessment for TB Medication Toxicity Revised 2/08

DOCUMENT USED IN : CC TUBERCULOSIS CLINIC

Texas Department of State Health Services
Order to Implement and Carry Out Measures For a Client with Tuberculosis

To: (Name)_____

(Address)_____

_____(Phone #)_____

I have reasonable cause to believe that your diagnosis, based on information available at this time, is (probably/ definitely) TUBERCULOSIS, which is a serious communicable disease. By the authority given to me by the State of Texas, Health and Safety Code, section 81.083, I hereby order you to do the following:

1. Keep all appointments with clinical staff as instructed.
2. Follow all medical instructions from your physician or clinic staff regarding treatment for your tuberculosis.
3. Come to the Public Health Department Clinic or be at an agreed location and time for taking Directly Observed Therapy (DOT).
4. Do not return to work or school until authorized by your clinic physician.
5. Do not allow anyone other than those living with you or health department staff into your home until authorized.
6. Do not leave your home except as authorized by your clinic physician.
7. Special Orders - see reverse side.
   YOU MUST UNDERSTAND, INITIAL AND FOLLOW THE INSTRUCTIONS ON THE BACK OF THIS ORDER.

This order shall be effective until you no longer need treatment for TUBERCULOSIS.

If you fail to follow these orders, court proceedings may be initiated against you as dictated by State law. After a hearing, the Court may order you to be hospitalized at The Texas Center for Infectious Diseases in San Antonio or another facility. The Court also has the option to order you to go to treatment at a health clinic. The court proceedings could also include having you placed in the custody of the County Sheriff until the hearing.

Signed this_____day of_____20___.

Health Authority of_____City/County
or Director, Public Health Region _____

Please sign in the space provided below to show that you received these orders and understand them.

I hereby acknowledge that I received a copy of these orders and understand them.

Signed _____ Date _____
(client's signature)

Witness _____ Date _____

TB-410 (rev. 08/04)

TEXAS Department of State Health Services

DOCUMENT USED IN : CC TUBERCULOSIS CLINIC

Attachment H: Mandated Forms

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
DISCLOSURE AND CONSENT
DRUG THERAPY FOR TREATMENT OF TUBERCULOSIS DISEASE

The information in this consent form is given so you can know more about your treatment. After you are sure that you understand this information, sign this form to show that you do understand and agree to take the treatment.

I have been told I need drug treatment because of: CIRCLE ONE

1. Tuberculosis, current disease
2. Tuberculosis suspect
3. Other mycobacterial disease

The following drugs have been prescribed: CIRCLE ALL THAT APPLY

1. Amikacin	6. Ethambutol (EMB)	11. Linezolid	16. Rifamate
2. Aminosalicylic acid	7. Ethionamide (ETH)	12. Moxifloxacin	17. Rifampin
3. Capreomycin	8. Isoniazid (INH)	13. Ofloxacin	18. Rifapentine
4. Ciprofloxacin	9. Kanamycin	14. Pyrazinamide (PZA)	19. Streptomycin
5. Cycloserine	10. Levofloxacin	15. Rifabutin	20. Other (please specify) _____

Some people who take these drugs may have one or more of the problems shown below:

Isoniazid	Tiredness, poor appetite, nausea, abdominal discomfort/bloating, vomiting, rash, tingling of fingers or toes, vision changes, dark urine, yellow skin. **Caution**: Avoid drinking alcohol and limit use of acetaminophen (Tylenol).
Rifampin	Orange body fluids (tears, urine, sweat). May stain soft contact lenses or clothing. Flu-like symptoms, fever, tiredness, poor appetite, nausea, abdominal discomfort/bloating, vomiting, yellow skin, itching, rash, change in urine output, bleeding. **Caution**: Avoid drinking alcohol. May reduce the effectiveness of birth control pills. If contraception is desired, an alternative method of birth control should be considered. Will interact with many other drugs.
Pyrazinamide	Tiredness, poor appetite, nausea, abdominal discomfort/bloating, vomiting, fever, joint pain, rash, dark urine, yellow skin, muscle aches. **Caution**: Avoid drinking alcohol.
Ethambutol	Vision changes, blurring, eye pain, red/green color blindness, tiredness, poor appetite, nausea, abdominal discomfort/bloating, vomiting, fever, headaches, dizziness, rash.
Rifamate	Same as Isoniazid plus Rifampin. **Caution**: Avoid drinking alcohol. Same birth control precautions as with Rifampin.
Rifabutin	Same as Rifampin. Also, eye pain or irritation of eyes, fever, rash, bleeding, vision changes, joint pain. **Caution**: Avoid drinking alcohol. Same birth control precautions as with Rifampin.
Rifapentine	Same as Rifampin. **Caution**: Avoid drinking alcohol. Same birth control precautions as with Rifampin.
Ethionamide	Tiredness, poor appetite, nausea, abdominal discomfort/bloating, vomiting, metallic taste, rash, depression, tingling of fingers or toes, dark urine, yellow skin, decreased energy, headaches, sleep difficulty, loss of concentration or memory, hair loss, skin changes, acne, enlarged breasts.
Amikacin, Capreomycin, Kanamycin, Streptomycin	Change in urine output, hearing loss, ringing in the ears, dizziness, loss of appetite, nausea or vomiting, increased thirst, numbness around face or mouth, muscle cramps.
Ciprofloxacin, Levofloxacin, Moxifloxacin Ofloxacin	Tiredness, poor appetite, nausea, abdominal discomfort/bloating, vomiting, fever, rash, headache, nervousness, increased gas, stomach cramps, dizziness, shakiness, sleep problems, depression, achiness, joint pain or swelling, pain in tendons usually at ankle, change in heart rate, fainting, trouble concentrating.
Cycloserine	Convulsions, sleep problems, headache, shakiness, dizziness, memory loss, depression, mood changes, abnormal behavior, seizures. **Caution**: Avoid drinking alcohol.
Aminosalicylic acid	Tiredness, poor appetite, nausea, abdominal discomfort/bloating, vomiting, dark urine, yellow skin. **Caution**: Avoid drinking alcohol.
Linezolid	Bleeding, fatigue/weakness, fainting, headache, dizziness, rapid pulse, diarrhea, nausea, vomiting, tingling of fingers or toes, vision changes.

Attachment H: Mandated Forms

Allergic reactions including rashes and hives may be caused by any of the drugs. If severe immune reactions occur (including swelling of lips, breathing difficulty or wheezing), stop taking the drug and contact the nurse or physician immediately; or, to seek emergency medical help, dial 911 or visit the ER (Emergency Room) at a hospital.

The risks are small and the health problems that may arise usually clear up completely. Sometimes the side effects may be bad, and very rarely they may cause lasting damage or death. The Texas Department of State Health Services will check me regularly for side effects. I will be responsible for telling my healthcare provider about any unusual symptoms and following treatment recommendations and instructions. The Texas Department of State Health Services believes that the benefits of drug treatment for tuberculosis disease is always much greater than the risks.

I have answered all of the questions about my medical history and my present health condition fully and truthfully. I have told the doctor or other clinic staff about any conditions that might suggest I should not take the medication(s). I have had the chance to ask questions about this health condition, the benefits and risks of specific tuberculosis drugs, including how long side effects may last and how bad the side effects may be. I understand the risks of not taking treatment. I understand that no promises can be made about cure or side effects. Any blank spaces on this form have been filled in. **By signing below, I consent to treatment for tuberculosis disease.**

SECTION I:

Patient's name: _____

Patient's Signature: _____ Date: _____

Person authorized to consent (if not patient): _____

Relationship: _____

Signature: _____ Date: _____

SECTION II:

I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Patient's name: _____

Name of person giving consent: _____

Signature: _____ Date: _____

Relationship to patient: _____ Phone: _____

Address: _____

SECTION III:

Counselor's Signature: _____ Date: _____

Interpreter's Signature (If used): _____ Date: _____

TB - 411 (Revised 05/07)

TEXAS Department of State Health Services

Attachment H: Mandated Forms

TEXAS Department of State Health Services

GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

NOTIFICATION: COLLIN COUNTY HEALTH CARE SERVICES
(Name of Health Department)
(hereafter called the Department) encourages individuals to seek a personal physician for periodic health examinations and for treatment of health problems. The Department clinic services are targeted primarily toward prevention of health problems among those who cannot access a physician. The Department cannot assume the responsibility for payment of medical care received outside this clinic, including the delivery of babies, unless previous authorization has been given.

DISCLAIMER ON SCREENING: Among its services, the Department utilizes screening tests, which are a method of identifying individuals who are at risk for developing several common medical problems. In this way they can alert you to promptly seek medical evaluation and treatment from a private physician of your choosing. Screening tests perform valuable service in helping to find certain diseases early in their course. However, these screening tests do not cover all diseases, and they may miss some cases of diseases they are intended to find. They are not diagnostic and they do not constitute a complete exam.

GENERAL CONSENT: I give permission to the Department, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests, give injections, medications, and other treatments, and render other health services to the patient identified on this form.

INFORMED CONSENT: In addition to the above general consent, I understand that special informed consent forms must be read and signed for the following procedures: medications for tuberculosis and Hansen's Disease, immunizations, injectable medication for sexually transmitted diseases, family planning methods, PKU special counseling, HIV testing, and certain other things.

PRIVACY NOTICE: I acknowledge that I have received a copy of the Department's HIPAA Privacy Notice.

QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in and that any questions I have had about the services have been answered to my satisfaction.

SIGNATURES: Fill blank lines with NA if not applicable.

SECTION I:

Patient's Name_____ Patient's Signature_____

Person Authorized to Consent (if not patient)_____ Relationship_____

Signature_____ Date_____

SECTION II: I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Patient's Name _____

Name of Person Giving Consent _____ Signature_____

Relationship to Patient _____ Date_____

Address_____

Phone Number_____

SECTION III:

Counselor Signature _____ Date_____

Attachment H: Mandated Forms

TEXAS Department of State Health Services

INFORMACION Y CONSENTIMIENTO

Se le da Ud. información en esta forma de consentimiento para que pueda informarse mejor sobre los servicios de salud que Ud. recibirá. Luego que Ud. esté seguro(a) de haber entendido la información sobre los servicios, y si está de acuerdo en recibirlos, debe firmar esta forma e indicar que la entiende y consiente a los servicios.

NOTIFICATION: COLLIN COUNTY HEALTH CARE SERVICES
(Nombre del Departamento de Salubridad)

(De hora en adelante llamado el "Departamento") anima a las personas a que busquen su propio médico para examenes de salud y tratamiento de problemas de salud. Servicios en las clíncas del Departamento son primeramente dirigidas a la prevención de problemas de salud para aquellas personas que no tienen acceso a un médico. El Departamento no puede tomar la responsabilidad de pagar por atención médica que Ud. reciba afuera de esta clínica, incluyendo partos, a menos que se hay dado previa autorización.

EXCEPCION DE PRUEBAS PRELIMINARES: Entre sus tratamientos el Departamento usará pruebas preliminares, las cuales son un método de identificar a esas personas que se encuentran en riesgo de enfermedades comunes. De esta manera el Departamento la puede avisar para que Ud. busque tratamiento de su propio médico lo mas pronto possible. Estas pruebas prestan un valioso servicio al descubrir ciertas enfermedades que existen antes de empezar el tratamiento. Sin embargo estas pruebas no cubren todas las enfermedades y es possible que no se identifiquen algunas enfermedades que se buscan. Estas pruebas no se consideran como un examén completo o de caracter diagnosticó.

CONSENTIMIENTO GENERAL: Doy permiso al Departamento, a sus empleados y otras personas médicas que prestan servicios bajo su patrocinio, para que hagan evaluaciónes o exámenes físicos, para llevar acabo exámenes de laboratorio o otras pruebas, para dar inyecciónes, medicinas, otros tratamientos y prestar otros servicios de salud al paciente nombrado en esta forma.

CONSENTIMIENTO CONFIRMADO: Ademas del consentimiento general dado, entiendo que formas especiales de consentimiento confirmado deben ser leidas y firmadas para los siguentes procedimientos: medicinas para la Tuberculosis, Enfermedad de Hansen, vacunas, medicinas o inyecciónes para enfermedades venereas, métodos de planificación familial, pruebas e información especial de PKU, la S.I.D.A. y algunas otras enfermedades.

AVISO SOBRE DERECHOS DE LA VIDA PRIVADA: Yo admito haber recibido una copia del Aviso Sobre Derechos de la Vida Privada (HIPAA) del Departamento.

PREGUNTAS: Certifico que esta forma me ha sido explicada ampliamente o que la forma se me ha leido, y que la entiendo. Todos los espacios indicados fueron marcados antes que yo firmara esta forma.

FIRMAS: Llene las líneas que no aplican con NA.

SECCIÓN I:

Nombre del Paciente _____ Firma _____

Persona Autoizada para dar el Consentimiento (No Siendo el Paciente) _____

Relación _____

Firma _____ Fecha _____

SECCIÓN II: Certifico que la persona que da el consentimiento no puede ser notificada y que no ha rehusado antes los servicios solicitados.

Nombre del Paciente _____

Nombre de la persona que da el Consentimiento _____

Firma _____ Relación al Paciente _____

Telefono _____ Fecha _____

Dirección _____

SECCIÓN III:

Firma del Consejero _____ Fecha _____

Department of State Health Services — Public Health Nursing L-36 (9/2004)

DOCUMENT USED IN : CC TUBERCULOSIS CLINIC

Department of State Health Services
Attachment H: Mandated Forms
Disclosure and Consent Human Immunodeficiency Virus (HIV) Test

TO THE PATIENT: The information in this consent form is provided so that you can be better informed about the Human Immunodeficiency Virus (HIV) Test. You must sign form to indicate that you understand and consent to the HIV test.

I understand that the test currently used by the Department of State Health Services is an antibody test, which means that it detects the presence of antibodies to HIV, not the virus itself.

- I understand that the test uses a sample of my blood, which will be taken from a vein in my arm.
- I understand that the test uses a sample of my blood, which will be taken from a prick to my finger.
- I understand that the test uses a sample of tissue from the cheek and gums, which will be taken by a special pad that I will place between my lower gum and inner cheek.

I understand that if the first test is positive, confirmatory testing in the form of a Western Blot will be needed.

If a traditional HIV antibody test was conducted using a tube of blood or a dried blood spot card, the confirmatory test will be conducted using the original sample that indicated the presence of antibodies.

If a rapid HIV test was done, an additional sample will need to be collected for confirmatory testing. Confirmatory testing can be conducted using one of the following options and will vary from one agency to another.

The three options are:

- an Orasure test that uses a sample of tissues from the cheek and gums,
- a tube of blood is drawn, or
- a dried blood spot card is completed using blood gathered from a finger stick.

I further understand that I will be considered to be infected with HIV only after a different test confirms that my blood is positive for the Human Immunodeficiency Virus (HIV).

I understand that neither of these tests diagnoses AIDS (Acquired Immunodeficiency Syndrome). I further understand that a positive result for either test does not indicate that I have AIDS at the present time or that I will develop AIDS in the future, but that I have probably been infected with HIV, which causes AIDS.

I understand that if I am told all my test results are positive, I have probably been infected with HIV, the virus that causes AIDS. I understand that knowing the test results can help me to make important decisions in my everyday life and that the information will be helpful to my health care providers. I also understand I may be referred for more extensive counseling, medical care, and other necessary referrals to help me.

I understand in addition to the knowledge that I will receive from having the test done, there are certain risks in having a test for HIV (the virus that causes AIDS) performed. A small percentage of tests may give a "false-positive" or a "false-negative" result. I understand that a "false-positive" result means that a test has incorrectly indicated I am infected with HIV when, in fact, I am not. I understand that a "false-negative" result means that a test has incorrectly indicated I am not infected with HIV when in fact, I have been. I understand a small percentage of results can be inconclusive and may require re-testing after a period of time.

I understand there is a chance that I have been exposed to HIV (the virus that causes AIDS) and my body may not have made enough antibodies which can be detected by the tests and I may need to repeat the tests at a later date.

I have answered all the questions about my medical history and my present health condition fully and truthfully.

I have had an opportunity to ask questions about the tests including the risks and benefits of taking these tests. Any questions I have about the tests have been answered to my satisfaction.

I understand the Department of State Health Services, its employees, nor the State of Texas has warranted the accuracy of the test results.

I understand that under the laws of the State of Texas, testing of HIV (the virus that causes AIDS) is strictly confidential and disclosure can be made to physicians, nurses, or other health care personnel who have legitimate need to know the test result(s) in order to provide for his/her protection and to provide for my health and welfare. Records will be handled in a confidential fashion, and personnel handling records have been advised of the laws addressing confidentiality in Texas.

Information about the tests has been given to me in the following manner: (check one) ☐ Orally ☐ Written

This form has been explained to me. (Check one) I have read the form ☐ or the form has been read to me ☐ and I understand its meaning.

All the blanks were filled in before the form was signed by me. _____

SIGNATURES

SECTION I:

Client/Patient's Names: _____

Person Authorized to Consent: _____ Relationship: _____

Signature: _____ Date: _____

SECTION II: I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Client/Patient's Name: _____

Name of person giving consent: _____ Relationship to patient (if not patient): _____

Address: _____ Date: _____

Phone number: _____

SECTION III:

Risk Reduction Specialist/Counselor's Signature: _____

J-6 (10-2007)

DOCUMENT USED IN : CC TUBERCULOSIS CLINIC

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
DISCLOSURE AND CONSENT
DRUG THERAPY FOR TREATMENT OF LATENT TUBERCULOSIS (TB) INFECTION

The information in this consent form is given so you can know more about your treatment. After you are sure that you understand this information sign this form to show that you do understand and agree to take the treatment.

I have been told I need drug treatment because of: CIRCLE ONE

1. Tuberculosis exposure, no evidence of infection.
2. Latent tuberculosis infection, no disease
3. Tuberculosis, no current disease

The following drugs have been prescribed: CIRCLE ALL THAT APPLY

1. Isoniazid (INH)
2. Rifampin
3. Pyrazinamide (PZA)
4. Ethambutol (EMB)
5. Rifabutin
6. Levofloxacin
7. Other _____ Please specify

Some people who take these drugs may have one or more of the problems shown below:

Isoniazid	Nausea, vomiting, loss of appetite, rash, tingling of fingers or toes, vision changes, dark urine, yellow skin. **Caution**: Avoid drinking alcohol and limit use of acetaminophen (Tylenol).
Rifampin	Orange body fluids (tears, urine, sweat). May stain soft contact lenses or clothing. Flu-like symptoms, tiredness, nausea, vomiting, loss of appetite, yellow skin, itching, rash, change in urine output, bleeding, fever. **Caution**: Avoid drinking alcohol. May reduce the effectiveness of birth control pills. If contraception is desired, an alternative method of birth control should be considered. Will interact with many other drugs.
Pyrazinamide	Nausea, vomiting, loss of appetite, fever, joint pain, rash, dark urine, yellow skin, muscle aches. **Caution**: Avoid drinking alcohol.
Ethambutol	It is possible that you will note changes in visual acuity and in red/green color discrimination, nausea, vomiting, loss of appetite, fever, headaches, dizziness, rash.
Rifabutin	Same as Rifampin. Also, eye pain or irritation of eyes, fever, rash, bleeding, vision changes, joint pain. **Caution**: Avoid drinking alcohol. Same birth control precautions as with Rifampin.
Levofloxacin	Nausea, vomiting, loss of appetite, fever, rash, headache, nervousness, increased gas, stomach cramps, dizziness, shakiness, sleep problems, depression, achiness, joint pain or swelling, pain in tendons usually at ankle, change in heart rate, fainting, trouble concentrating.

Allergic reactions including rashes and hives may be caused by any of the drugs. If severe immune reactions occur (including swelling of lips, breathing difficulty or wheezing), stop taking the drug and contact the nurse or physician immediately; or, to seek emergency medical help, dial 911 or visit the ER (Emergency Room) at a hospital.

DOCUMENT USED IN :
CC TUBERCULOSIS CLINIC

e health problems that may arise usually clear up completely. Sometimes the side effects may be bad, and very rarely they may cause lasting damage or death. My healthcare provider will check me regularly for side effects. I will be responsible for telling my healthcare provider about any unusual symptoms and following treatment recommendations and instructions. The Texas Department of State Health Services believes that the benefits of drug treatment for latent TB infection are usually much greater than the risks.

I have answered all of the questions about my medical history and my present health condition fully and truthfully. I have told the doctor or other clinic staff about any conditions that might suggest I should not take the medication(s). I have had the chance to ask questions about this health condition, the benefits and risks of specific tuberculosis drugs, including how long side effects may last and how bad the side effects may be. I understand the risks of not taking treatment. I understand that no promises can be made about prevention of disease or side effects. Any blank spaces on this form have been filled in.

Based on all the above and on what I have been told of the benefits as well as the risks of taking medicine for latent TB infection,

(CIRCLE ONE) **I consent** **I do not consent**

to the treatment for latent TB infection as recommended.

SECTION I:

Patient's name: _____

Patient's Signature: _____ Date: _____

Person authorized to consent (if not patient): _____

Relationship: _____

Signature: _____ Date: _____

SECTION II:

I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Patient's name: _____

Name of person giving consent: _____

Signature: _____ Date: _____

Relationship to patient: _____ Phone: _____

Address: _____

SECTION III:

Counselor's Signature: _____ Date: _____

Interpreter's Signature (If used): _____ Date: _____

TB - 415 (Revised 01/09)

TEXAS Department of State Health Services

Texas Department of State Health Services
Tuberculosis Education/Counseling Record

NAME: _____ D.O.B.: ___/___/___ SS#: ___/___/___

Instructions:
1. Provide appropriate Education/Counseling to ALL TB clients.
2. Each client must have an education/counseling plan based on individual assessment and need.
3. This tool serves as a guideline but education/counseling should not be limited to this information only.
4. Initial each box as education/counseling is performed.
5. The (Y) indicates when instruction should occur.
6. Standardized printed materials (in client's preferred language, if available) are provided to client on the initial visit.
7. Staff providing client education must be familiar with reference information listed in the TB standing delegation orders.

Language used for education/ counseling:

Interpreter names:

Comments:

	[redacted]									
TRANSMISSION/PATHOGENESIS: • Signs/symptoms of TB disease • Airborne disease / Shared airspace • Infectiousness of case • PPD(+) 2-10 weeks after initial infection • TB infection vs. disease	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
INFECTION CONTROL MEASURES: • Proper use of masks and tissues • Isolation/return to work after 3 negative smears, clinically improved, DOT for 2 weeks • Sputum collection	Y	Y	Y	Y						
EVALUATION: • PPD testing/significance, CXR results, other tests	Y						Y			Y
HIGH RISK GROUPS/FACTORS: • Diabetics, Silicosis, HIV+, Gastric resection • Alcohol/drug abuse (IVDU), Underweight • Corticosteroids, TNF-alpha antagonists • Foreign born, Resident of correctional or long term care facility	Y	Y	Y							
MEDICATION: • Possible side effects, actions to take if side effects occur • Increased risk of side effects if post-partum, alcohol abuse, kidney or liver disease • Benefits = cure of disease or prevention of disease • Administration = dosage/frequency, length of treatment, DOT/DOPT	Y	Y	Y							
DRUG INTERACTIONS: • INH: Tylenol, anticoagulants, valium, carbamazepines, disulfiram, haldol, ketoconazole, dilantin, theophyllin, valproate • Rifampin: anticoagulants, antidepressants, beta-blockers, oral contraceptives, corticosteroids, protease inhibitors, delavirdine, efavirenz, digoxin, diltiazem, fluconazole, itraconazole, haloperidol, methadone, dilantin, verapamil, tetracyclines, trimethoprim-sulfa, chloramphenicol	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
ADHERENCE: • Case = control order, quarantine, MDR-TB, death • LTBI = disease later, DOPT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RATIONALE FOR DOT/DOPT: • Assure compliance and adherence • DOT = prevents drug resistance and is Standard of Care • DOPT = age <5, HIV+, contacts to MDR-TB, other high risk	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

TEXAS Department of State Health Services

DOCUMENT USED IN : CC TUBERCULOSIS CLINIC

Attachme

RATIONALE FOR MONTHLY MONITORING: • Assess improvement/worsening of symptoms • Toxicity/symptom review, LFTs/other lab per protocol • Medication refill	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
LAB RESULTS: • LFTs/other lab per protocol • Sputum per protocol • Evaluation of sputum conversion	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
HIV • Affect of HIV infection on progression to TB disease • HIV post test counseling	Y									
SPUTUM/SPECIMEN COLLECTION: • Early morning specimen, One supervised monthly • Weekly, till 3 consecutive negative smears • Monthly, till 2 consecutive months negative cultures • Collect outdoors or in room with negative air pressure	Y	Y	Y	Y	Y					
CONTACT INVESTIGATION: • Rationale = find new disease, detection and treatment of LTBI • 2nd testing of negative contacts, 8-10 weeks after break in contact • Concentric circle approach	Y		Y							
CONSENTS/AUTHORIZATIONS: • Consents explained • Copies given to patient	Y									
PROVIDER INFORMATION: • Clinic address/phone number • Nurse case manager's name/phone number	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

DSHS-Bete	English Spanish Vietnamese	TB-What You Should Know									
DSHS-Bete	English Spanish	TB And HIV-Know The Risk									
CDC 00-5983	English	TB Facts-Exposure to TB									
CDC 00-6200	Spanish	TB Facts-Exposure to TB									
CPIDC	English Spanish	What You Need to Know About TB									
CCHC		Low Cost Health Clinic									
		Provider Initials:									
		Interpreter Initials:									
		Next Appointment:									

TEXAS DEPARTMENT OF HEALTH
DISCLOSURE AND CONSENT TREATMENT FOR SEXUALLY TRANSMITTED DISEASES BY INJECTABLE MEDICATION

The information in this consent form is provided so that you can be better informed about the treatment prescribed for you. After you are sure that you understand the information about the treatment recommended for you and, if you agree to receive this treatment, you must sign this form to indicate that you understand and consent to the treatment.

It has been recommended that I receive an injectable medication because (check one) I have ( ) or have been exposed to ( ) _____, which is a sexually transmitted disease. I understand that the drug recommended for treatment ( ) or preventive care ( ) is:

(Check Drug Prescribed)	(Drug Number)
( ) Benzanthine Penicillin G (2.4 million units)	1
( ) Spectinomycin Hydrochloride (2.0 gm)	2
( ) Cefoxitin (____ 1.0 gm) (____ 2.0 gm)	3
( ) Ceftriaxone (____125 mg) (____ 250 mg)	4

I understand that there may be risks and hazards if I do not choose to receive treatment for my condition. Further, I understand that the drug which has been prescribed for me may carry certain risks and hazards which are listed by drug number below:

(Drug Number)	(Side Effects)
1,2,3,4	Severe or fatal allergic reactions (shock, swelling, breathing problems);
1,2,3,4	Other allergic reactions (skin rashes, itching, fever, chills);
1,3,4	Blood changes/Anemia;
1	Convulsions;
1,2,3,4	Pain/sterile abcess at injection site;
2,3,4	Gastrointestinal problems;
2,3,4	Kidney problems;
3	Tissue sloughing;
1	Nerve involvement;
2	Numbness or tingling

I understand that I am responsible for any costs related to any complications which I experience resulting from the administration of injectable medications.

I have answered all of the questions about my medical history and my present health condition fully and truthfully. I have told the physician or other clinic personnel about all conditions, including allergies, which might indicate that I should not receive the injectable medication.

I have had the opportunity to ask questions about this sexually transmitted disease or exposure, the risks of not accepting treatment, alternative forms of treatment, the benefits and the risks and hazards of the drug prescribed, and the severity and duration of the indicated side effects. These questions have been answered to my satisfaction. I understand that neither the Texas Department of Health, its employees, nor the State of Texas has warranted or guaranteed the safety of effectiveness of the treatment indicated.

Based upon all the above, I believe that I have received sufficient information to give, and I do give, this informed consent for the administration of the injectable medication as prescribed.

This form has been explained to me. I have read the form ( ) or the form has been read to me ( ) and I understand it. All the blank spaces were filled in before I signed the form.

SIGNATURES

SECTION I:

Patient's Name _____ Patient's Signature _____

Person Authorized to Consent (if not patient): _____ Relationship _____

Signature _____ Date _____

SECTION II: I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Patient's Name _____

Name of Person giving consent _____ Date _____

Relationship to Patient _____

Address _____

Phone Number _____

SECTION III:

Counselor Signature _____ Date: _____

Stock No. STD-42 1/94

EL DEPARTAMENTO DE SALUD DE TEJAS

CONSENTIMIENTO DE ENFERMEDADES TRANSMISIBLES SEXUALMENTE CON MEDICAMENTO INJECTABLES

El propósito de este consentimiento médico es para informale sobre su tratamiento médico. Al entender esta información, y estar de acuerdo a recibir el tratamiento, debe indicar este acuerdo con su firma.

Se ha recomendado que yo reciba medicamento injectable porque (marqué uno), tengo ( ), fui expuesto a ( ) _____ que es una enfermedad transmisible sexualmente. Entiendo que este medicamento se recomenda como ( ) tratamiento ( ) medida preventiva.

(Marqué la medicina recetada)	(Numero do la medicina)
( ) Benzanthine Penicillin G (2.4 million units)	1
( ) Spectinomycin Hydrochloride (2.0 gm)	2
( ) Cefoxitin (____ 1.0 gm) (____ 2.0 gm)	3
( ) Ceftriaxone (____125 mg) (____ 250 mg)	4

Entiendo que hay riesgos si decido no eligir tratamiento para me condición. También entiendo que esta medicina que se me ha recetado tiene los siguientes riesgos:

(Numero da la Medicina)	(Riesgos)
1,2,3,4	Reacción fatal o severo, (Choque, hinchazón, problemas con la respiracion);
1,2,3,4	Otras reacciónes alérgicas (roncha, comezón, fiebre, escalofrío);
1,3,4	Cambios en la sangre/anemia;
1	Convulsiónes;
1,2,3,4	Dolor/absceso estéril en el sitio de injección;
2,3,4	Problemas gastrointestinal;
2,3,4	Problemas de los riñones;
3	Destrucción de la piel;
1	Complicación en las cuerdas nerviosas;
2	Adormecimiento o picazon

Entiendo que los gastos que ocurran como resultante de complicaciones de estas medicinas son mi responsabilidad.

Yo he respondido verdadamente a todas las preguntas sobre mi historia médica y mi condición de salud presente. Yo le he dicho al médico o otro personal de la clinica de todas mis condiciónes médicas incluyendo alérgias, que puedan indicar que yo no debo recibir este medicamento injectable. He tenido la oportunidad de hacer preguntas sobre mi situación, los reisgos de rechazar el tratamiento, otra formas de tratamiento, beneficios y riesgos de medicamento recetado y la severidad y duración de los riesgos indicados. Todas mis preguntas se han contestado a mi satisfacción.

Tengo entendido que ni el Departamento de Salubridad de Tejas, o sus empleados, ni el estado de Tejas garantizan la seguridad o efectividad del tratamiento indicado.

Segun la información presentada, creo que tengo suficiente información para dar, y doy, mi consentimiento médico a la administración para recibir este medicamento injectable como se ha recetado.

Esta forma se me ha explicado. La he leído ( ) o, se me ha leído ( ), y yo la entiendo. Todos los espacios en blanco se completaron antes que di mi firma.

FIRMA

SECTION I:

Nombre de paciente _____ Firma de paciente _____

Persona Autorizada para Consentimiento (si no es el paciente): _____

Relación _____

Firma _____ Fecha _____

SECCION II: Yo certifico que la persona que tiene el poder de consentimiento no se encuentra y previamente no ha rechazado estos servicios.

Nombre de paciente: _____

Nombre de persona dando el consentimeinto: _____ Fecha _____

Relación al paciente: _____

Dirección _____

Numero de teléfono: _____

SECCION III:

Firma de Consejero: _____ Fecha: _____

Stock No. STD-42 1/94

Attachment H: Mandated Forms

DOCUMENT USED IN :
CC STD CLINIC

DEPARTMENT OF STATE HEALTH SERVICES CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES (STD)

All physicians who diagnose or treat a reportable sexually transmitted disease and others required to report shall report it within seven (7) days.
Complete all spaces or check all boxes as appropriate. Shaded areas are not required by law, but necessary for appropriate identification or follow-up.

Patient's Name (Last, First, MI.)	Birth Date	Age	Sex M ☐ F ☐	Pregnant? Y ☐ N ☐
Address (Street, City, State, Zip)	Hispanic Ethnicity Yes ☐ No ☐	Race: *check all that apply* W ☐ B ☐ AIS ☐ AI ☐ PI ☐		
Telephone:	Employment	Marital Status: S ☐ M ☐ W ☐ D ☐	Medical Record #	

Exam Date:

Provider Codes ☐ HIV Sites ☐ STD Clinic ☐ Drug Treatment ☐ Family Planning Sites ☐ Prenatal/OB clinic ☐ TB Clinic ☐ Other Clinic ☐ Private Phy/HMO ☐ Hospital ☐ Emergency ☐ Correctional Facility ☐ Laboratory ☐ Blood/Plasma ☐ Other

Lab Results:

Exam Reason: ☐ DIS Partner Referral ☐ DIS Suspect Referral ☐ Referred by Partner ☐ Prenatal ☐ Delivery ☐ Screening in Jail/Prison ☐ Other Screening ☐ Referred by another provider ☐ Volunteer

Treatment Given: Date: ☐ **No Treatment Given**

100 **Chancroid**

200 **Chlamydia** (Not PID)
☐ Genital
☐ Ophthalmia

490 Pelvic Inflammatory Disease
Disease: ☐ Chlamydia ☐ Gonoccocal ☐ Other or Unknown Etiology

300 **Gonorrhea** (Not PID)
☐ Genital ☐ Pharyngeal
☐ Rectal ☐ Ophthalmia
☐ Other ☐ Resistant GC

600 **LGV** ☐

700 **Syphilis**
☐ Primary (Lesions)
☐ Secondary (Symptoms)
☐ Early Latent (< 1 year)
☐ Late Latent (> 1 year)
☐ Late (with Symptoms)
☐ Congenital Syphilis

Y ☐ N ☐ Unk. ☐ Neurologic involvement

900 **HIV Non-AIDS** ☐
HIV With AIDS ☐

Reporting HIV on this document serves as proof of timely report; however, the health department requires additional information on HIV patients.

☐ **Send my office additional cards**

Reported by:

Collin County Health Care Services
825 N. McDonald St. McKinney, TX 75069
Ph: (972) 548 5500 Metro (972) 424-1460 ext. 5500

Beby NP

Name | Office Address | City | Phone Number

STD-27 (Rev 10/2005)

Attachment H: Mandated Forms

DOCUMENT USED IN :
CC STD CLINIC

TEXAS DEPARTMENT OF STATE HEALTH SERVICES CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES (STD)

Use the spaces below to report your patient's sexual or needle sharing partners for confidential notification by Disease Intervention Specialists (DIS). When those listed below are notified of exposure, the DIS will not reveal your patient's identity.

Please consult with me or my designated staff before contacting my patient: ☐

Designated Staff Person | Telephone | Extension | Best time to call me or my staff

Partner's Name (Last, First)	Nickname or Alias:	Race	Sex	Age
Partner's Address (Street, Apartment, City, State)	Telephone: Home _____ Work _____	Best time to call or visit partner:		
Date of last exposure to patient: Partner's Marital Status	Partner's Place of Employment: Work Hours:	**I have examined and/or treated this partner** ☐ **Yes** ☐ **No**		
Partner's Name (Last, First)	Nickname or Alias:	Race	Sex	Age
Partner's Address (Street, Apartment, City, State)	Telephone: Home _____ Work _____	Best time to call or visit partner:		
Date of last exposure to patient: Partner's Marital Status	Partner's Place of Employment: Work Hours:	**I have examined and/or treated this partner** ☐ **Yes** ☐ **No**		

Mail to local health department or DSHS HIV/STD Control Program. Call (512) 533-3000 for the address of your local or regional health authority.

For more information, go to www.dshs.state.tx.us/hivstd

TEXAS Department of State Health Services

Attachment H: Mandated Forms

SCREEN FOR CHILD SEXUAL ABUSE REPORTING

POSSIBLE REPORT:

(Report required if partner is > 3 years older than client. If age of partner is unknown, a report **must** be filed per Texas Department of Health instructions posted 4/15/2003).

_____ Never married female, < 17 years of age, with positive pregnancy test or verbal declaration of pregnancy.
_____ Never married female, < 17 years of age, who has given birth to a child.
Child's age _____
_____ Never married female, < 17 years of age, presumed sexually active due to seeking a pregnancy test, a test for Sexually Transmitted Disease, or contraceptives.
_____ Never married female/male, < 17 years of age, with positive Sexually Transmitted Disease.
_____ Never married female/male, < 17 years of age, not included in the above categories, and reports being sexually active.

No Report Required As:

_____ **Report Required**
(Also see MANDATORY REPORT below)

_____ Client states she is married
(Common law marriages are not recognized if client is < 18 y/o)
_____ Partner is < 3 years older than client
Client age _____ Reported partner age _____

MANDATORY REPORT: (Report always required)

_____ Female, < 14 years of age, with positive pregnancy test or verbal declaration of pregnancy.
_____ Female/male, < 14 years of age, with positive Sexually Transmitted Disease acquired in a manner other than through perinatal transmission or transfusion.
_____ Female, < 14 years of age, who has given birth to a child.
Child's age _____
_____ Female/male, < 14 years of age, who reports sexual contact not described in other categories above.
_____ Female/male, < 17 years of age, who reports sexual contact with person of the same sex.
_____ Female/male, < 17 years of age, who reports duress, force, or threat at the time of contact.

REPORT OF SUSPECTED CHILD ABUSE

Chapter 261.001(1)(E) of the Texas Family Code defines child abuse as neglect, lack of supervision, and/or sexual conduct harmful to a child's mental, emotional, or physical welfare, including conduct that constitutes the offense of indecency with a child under Section 21.11, Penal Code, sexual assault under Section 22.011, Penal Code, or aggravated sexual assault under section 22.021, Penal Code. The victim of a crime, by definition, suffers mental, emotional, or physical harm. Collin County Health Care Services STD/HIV Clinic by policy and by contractual obligations with the Texas Department of State Health Services, is making a good faith effort to report all cases of suspected child abuse identified in our clinics.

Child's Name:

Address:

City:_____, Texas Zip:_____ County:

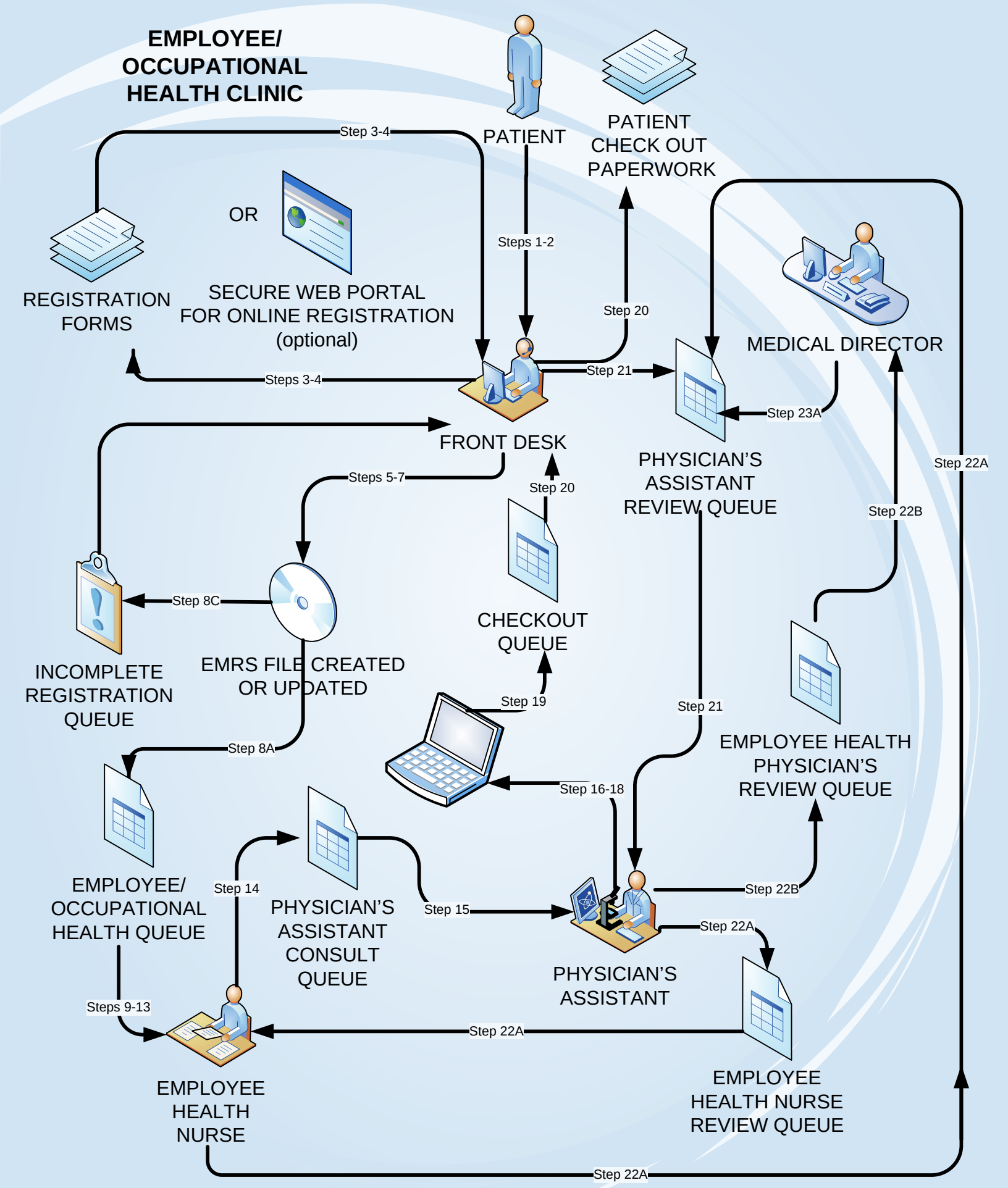
Date of Birth:_____ Social Security Number (optional):

Name of Parent or Guardian:

Parent or Guardian's Address:

Collin County Health Care Services
STD Clinic - (972) 548-5529
825 N. McDonald, Suite 130
McKinney, Texas 75069

Collin County Health Care Services Direct Patient Care Workflows



EMPLOYEE/OCCUPATIONAL HEALTH DIRECT PATIENT CARE (Page 1)

Step 1) Patient calls CCHCS for an appointment with or walks into the Employee Health Clinic at CCHCS and Front Desk staff calls the patient name in order for either 1) patient to receive the Registration forms and paperwork needed for their visit or 2) for Front Desk staff member to review Patient Registration forms submitted online for accuracy/completeness

Step 2) All patient forms are stored as templates with digital barcodes in EMRS and staff is able to print blank forms individually or en masse for patients to fill out/keep as the need arises; once forms are completed by the patient and scanned, EMRS also needs to provide dynamic indexing (i.e. areas of the patient's EMRS record are linked to the barcode printed on the form—the scanned Patient History form is stored under the "Patient History" tab/folder/section of the record, the scanned Immunization Screening Questionnaire is stored under the "Immunizations" tab/folder/section of the patient's EMRS record, etc…):

- Patient Registration Forms
- Patient Health History
- Existing Immunization Record; In the event the patient did not bring their immunization record, a copy of it may be also be accessed by Front Desk staff members by signing on to the TWICES or ImmTrac secure websites and printing the screen to a template with a digital barcode which can be printed, scanned, and saved into the patient's EMRS record)
- Immunization Screening Questionnaire
- Notice of Privacy Practices (for patient to keep)
- Acknowledgment of Receipt of Notice of Privacy Practices
- Patient's picture/electronic signature captured and/or saved

Step 3) Patient fills out and turns in any necessary paper forms to Front Desk Staff for data entry and scanning.

Step 4) **For paper documents filled out in person:**

- Front Desk staff members need desktop duplex color scanners to scan the forms mentioned above into the patient's EMRS record as individual PDF's which are automatically saved with a date/time stamp under the file location associated with the printed barcode on the form

For documents filled out online, the EMRS needs to:

- allow for the Front Desk staff member to print the documents on paper with a digital barcode and a date/time stamp so that patient's can sign them
- the Front Desk staff member then scans the document so the PDF image is automatically filed under the location associated with the barcode on the form

Step 5) Front Desk staff member searches the EMRS to see if the patient already exists.

- If the patient is a new patient, the Front Desk Staff member 'creates' a new patient EMRS file
- If the patient's file already exists, the Front Desk staff member reviews and/or edits the patient's information as needed

Step 6) Front Desk staff members enters/updated the following data into the EMRS:

- Patient Demographics
- Contact Information including preferred method of contact (phone, email, USPS mail)
- Financial/Insurance/Information (Of note, the EMRS needs to have an option to identify whether the patient is 1) a Collin County employee or dependent, or 2) a State employee or dependent, or 3) general public, since payment/billing will be tied into these profiles
- Reason for Visit (option to check boxes and have a general comments box—see document labeled "Fee Schedule" in Attachment B); boxes checked can trigger payment required

Step 7) Front Desk staff member:

- reviews/acts on any special instructions and system-generated messages regarding additional appointments needed and/or missing information; System features should include checks which restrict the user from going to the next screen/step unless certain fields have been completed
- is flagged to collect a co-pay only in instances where the patient is a State Employee; patient submits payment to the Front Desk staff member in cash, check, credit card

EMPLOYEE/OCCUPATIONAL HEALTH DIRECT PATIENT CARE (Page 2)

Step 8) Next, the Front Desk staff member can choose to:

- A) mark the patient as checked in and place the patient into the "Employee/Occupational Health Queue" based on the time the patient's information was completed or
- B) save the patient's file without transferring to the direct patient care workflow or
- C) placing the patient in an "Incomplete Registration Queue" in instances where a patient is missing a document for registration but still needs to be monitored; for example, the patient forgets to bring their immunization record and their primary care physician is faxing the document, we want to make sure the patient is not 'forgotten' while they are waiting for the document to be faxed to the nursing staff
- If choosing option B or C, there should be an added security prompt to ensure that the end user doesn't accidentally misroute the patient
- Of note, since patients frequently request services from more than one clinic, it is desirable for patients to be able to be placed in multiple queues so that they can be seen by the first available clinic; also staff members need to be able to have a clear alert when the patient has requested services from multiple clinics so that they can be transferred to the next clinic's queue seamlessly
- CCHCS staff should be able to view the queues to their respective clinics based on the user's security access in order to provide customer feedback on wait times as well as to manage staff resources

Step 9) Employee Health Nurse has a computer/notebook/laptop which is 'activated' to receive patients once the nurse signs into it; It is important that the computer/notebook/laptop can be connected to an additional monitor so that the nurse can view the EMRS on one screen and additional document/sites on the second screen

Step 10) EMRS sends the information of the next patient in line in the "Employee/Occupational Health Queue" to an available Employee Health Nurse's computer

Step 11) The patient's information, scanned documents, color-coded elapsed wait time, and reason for visit are displayed on the Employee Health Nurse's notebook/laptop

Step 12) Employee Health Nurse directs patient into an examination room

Step 13) Employee Health Nurse accesses patient's EMRS file and updates/enters/reviews essential information such as: current vital signs, lab results, progress notes, current medications, changes in health history, etc…

Step 14) Once the patient is ready to be seen by the Physician's Assistant, the Employee Health Nurse has the option to save the file and transfer the patient to the "Physician's Assistant Consult Queue"

Step 15) Physician's Assistant has a laptop/notebook with the same features as listed above and the EMRS sends the information of the next patient in line in the queue to his computer

Step 16) Physician's Assistant evaluates the patient, discusses reason for visit, provides needed treatment, and updates the patient's EMRS file as needed; the EMRS also allows the Physician's Assistant to use checklists in order to enter/modify/clarify the scanned patient history information (i.e., allergies, medications, medical conditions, etc…)

Step 17) Physician's assistant uses EMRS tools to generate any form letter, prescription, referral letter, or other document for patient use, or use by another department/outside agency based on templates developed by CCHCS (the ability to stamp/attach a digital signature on these types of documents is highly desired)

Step 18) Physician's Assistant enters any future reminder dates in a "Reminder Date" section of the EMRS which can be queried and activated for future automatic patient reminder notifications based on patient's selected method of notification (USPS mail, email, or phone notification). The information will be printed as a "Reminder" during the checkout process at the front desk

Step 19) Physician's Assistant transfers the patient to the "Checkout Queue"

EMPLOYEE/OCCUPATIONAL HEALTH DIRECT PATIENT CARE (Page 3)

Step 20) Patient goes to the Front Desk where any receipt/prescription/letters/forms/paperwork/discharge instructions/ are printed for the patient.

- If the patient sets up a follow-up appointments at time of checkout, the reminder will be labeled on the discharge paperwork as "Scheduled Appointment" and the "Reminder Date(s)" entered by the Physician's Assistant will not show
- If the patient declines to set up a follow-up appointment, the "Reminder Date(s)" will be labeled as "Remember to Contact Us to Set Up an Appointment For" on the discharge paperwork
- EMRS will send out phone/email/mail reminder based on preferences entered in the registration process prior to patient's next appointment

Step 21) Once all necessary steps are completed, the Front Desk staff member electronically marks the patient visit as 'completed' which places the patient's EMRS record into the "Physician's Assistant Review Queue" for chart review

Step 22) Physician's Assistant has the option to either:

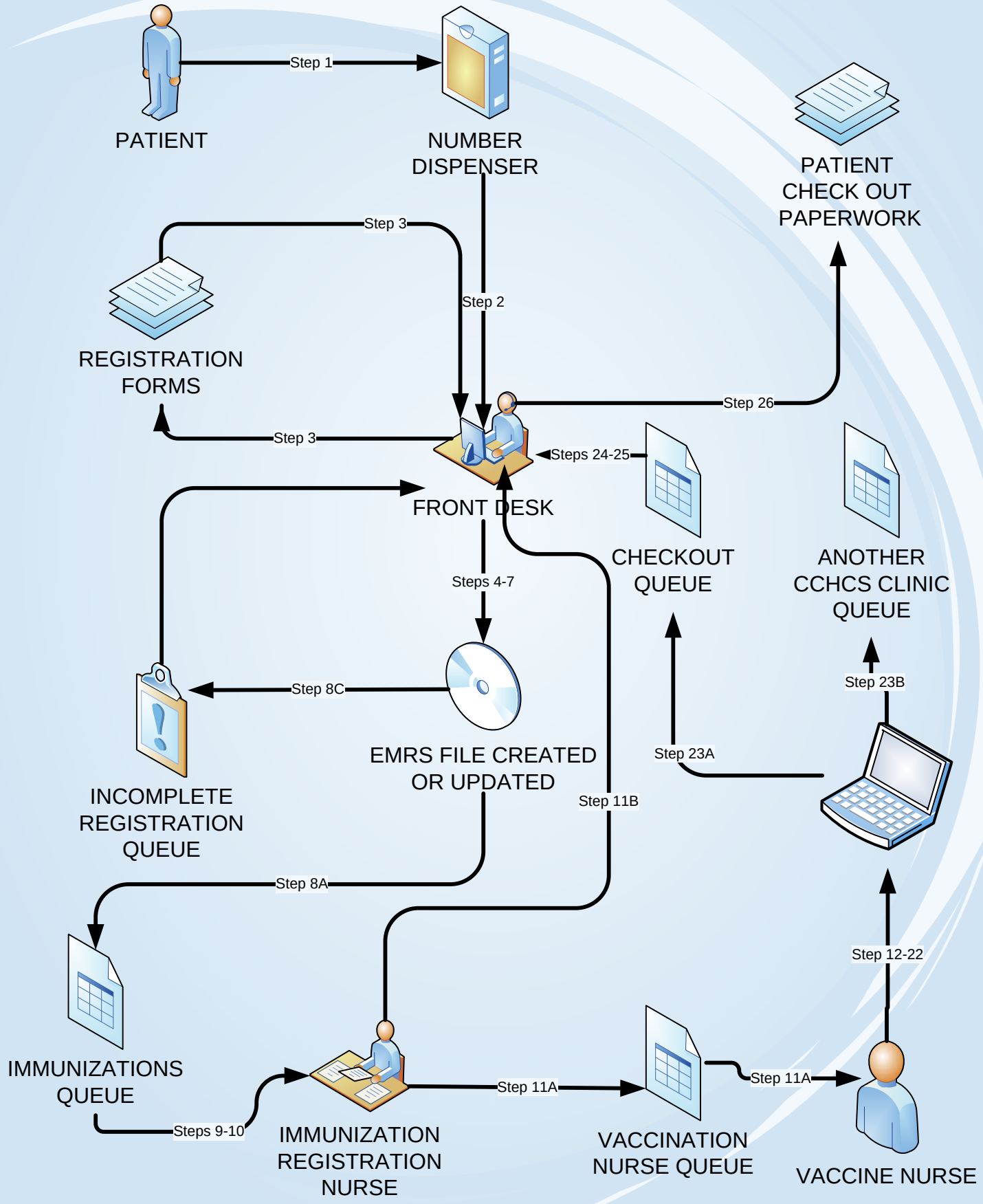
- A) Review/edit/update the EMRS, and transfer the patient's file to the "Employee Health Nurse Review Queue" for chart review; If this option is chosen, the Employee Nurse can access this queue, make and save any updates/changes, and only has the option to transfer the EMRS file back to the "Physician's Assistant Review Queue" for chart review
- B) Review/edit/update the EMRS, and transfer the patient's file to the "Employee Health Physician's Review Queue" for final review and completion from the Medical Director

Step 23) Medical Director has the option to:

- A) Review/edit/update the EMRS and marks the patient's file as "Review Incomplete" which places the patient's EMRS record back into the "Physician's Assistant Review Queue"
- B) Review/edit/update the EMRS and marks the patient's file as "Review Complete" which closes out the patient's visit

Collin County Health Care Services Direct Patient Care Workflows

IMMUNIZATIONS CLINIC



IMMUNIZATIONS DIRECT PATIENT CARE (Page1)

Step 1) Patient takes a number from the CCHCS lobby area and Front Desk staff calls the patient's number in order for patient to receive the Registration forms and paperwork needed for their visit

Step 2) All patient forms are stored as templates with digital barcodes in EMRS and staff is able to print blank forms individually or en masse for patients to fill out/keep as the need arises; once forms are completed by the patient and scanned, EMRS also needs to provide dynamic indexing (i.e. areas of the record are linked to the barcode printed—the scanned Patient History form is stored under the "Patient History" tab/folder/section of the patient's EMRS record, the scanned Immunization Screening Questionnaire is stored under the "Immunizations tab/folder/section of the patient's EMRS record, etc…):

- Patient Registration forms
- Patient Health History
- Existing Immunization Record; In the event the patient did not bring their immunization record, a copy of it may be also be accessed by Front Desk staff members by signing on to the TWICES or ImmTrac secure websites and printing the screen to a template with a digital barcode which can be printed, scanned, and saved into the patient's EMRS record)
- Immunization Screening Questionnaire
- Notice of Privacy Practices (for patient to keep)
- Acknowledgment of Receipt of Notice of Privacy Practices
- Patient's picture/electronic signature captured and/or saved

Step 3) Patient fills out and turns in paper forms to Front Desk Staff for data entry/scanning.

Step 4) Front Desk staff need desktop duplex color scanners to scan the forms mentioned above into the patient's EMRS record as individual PDF's which are automatically saved with a date/time stamp under the file location associated with the barcode on the form

Step 5) Front Desk staff member searches the EMRS to see if the patient already exists.

- If the patient is a new patient, the Front Desk Staff member 'creates' a new patient EMRS file
- If the patient's file already exists, the Front Desk staff member reviews and/or edits the patient's information as needed

Step 6) Front Desk staff members enters/updates the following data into the EMRS:

- Patient Demographics
- Contact Information including preferred method of contact (phone, email, USPS mail)
- Financial/Insurance/Information (Of note, the EMRS needs to have an option to identify whether the patient is 1) a Collin County employee or dependent, or 2) a State employee or dependent, or 3) general public, since payment/billing will be tied into these profiles
- Reason for Visit (option to check boxes and have a general comments box—see document labeled "Fee Schedule" in Attachment B); boxes checked can trigger payment required

Step 7) Front Desk staff members reviews/acts on any special instructions and system-generated messages regarding additional appointments needed and/or missing information; System features should include checks which restrict the user from going to the next screen/step unless certain fields have been completed

Step 8) Once the patient file is created and/or updates are saved, the Front Desk staff member can choose to:

- A) mark the patient as checked in and place the patient into the "Immunizations Queue" based on the time the patient's information was completed or
- B) save the patient's file without transferring to the direct patient care workflow or
- C) placing the patient in an "Incomplete Registration Queue" in instances where a patient is missing a document for registration but still needs to be monitored; for example, the patient forgets to bring their immunization record and their primary care physician is faxing the document, we want to make sure the patient is not 'forgotten' while they are waiting for the document to be faxed to the nursing staff
- If choosing option B or C, there should be an added security prompt to ensure that the end user doesn't accidentally misroute the patient

IMMUNIZATIONS DIRECT PATIENT CARE (Page2)

Step 8) (continued)

- Of note, since patients frequently request services from more than one clinic, it is desirable for patients to be able to be placed in multiple queues so that they can be seen by the first available clinic; also staff members need to be able to have a clear alert when the patient has requested services from multiple clinics so that they can be transferred to the next clinic's queue seamlessly

Step 9) Immunization Registration Nurse needs two computer monitors to view the patient's EMRS record side by side and compare with the secure TWICES website information

Step 10) Immunization Registration Nurse reviews documents scanned at Front Desk and enters the complete immunization record both into the EMRS and into the TWICES website which includes: vaccination dates, vaccination types, ImmTrac record number, TWICES record number

Step 11) Once all data is entered/reviewed by the Immunization Registration Nurse, the nurse has the options to:

- A) checks boxes in the EMRS for vaccinations indicated that the patient needs and is able to select an option to save the record and send the patient to the "Vaccination Nurse Queue"
- B) select an option for the record to be saved and the patient be sent to the "Checkout Queue" because the vaccine schedule indicates that it is too early to receive the vaccination; in these type of instances, it is desirable for the nurse to be able to have a comments field to explain the timeframe the patient should return to receive the vaccinations requested, go to Step 26

Step 12) Vaccine Nurse. has a computer/notebook/laptop which is 'activated' to receive patients once the nurse signs into it; It is important that the computer/notebook/laptop can be connected to an additional monitor so that the nurse can view the EMRS on one screen and the secure TWICES website on the second screen

Step 13) EMRS sends the information of the next patient in line in the "Vaccination Nurse Queue" to an available Vaccine Nurse's computer

Step 14) The patient's information, including vaccinations needed and color-coded elapsed wait time, are displayed on the notebook/laptop

Step 15) Vaccine Nurse checks off in the EMRS the vaccinations being given and the nurse is able to select vaccine lot numbers which have been previously entered into the EMRS system for ease of data entry; Vaccine Nurse also enters the vaccine type and vaccine lot numbers into the separate secure TWICES website so that the EMRS and TWICES are mirrored records

Step 16) Vaccine Nurse pulls the vaccine from refrigerated storage

Step 17) Vaccine Nurse directs patient into an examination room

Step 18) Vaccine Nurse discusses the vaccinations needed with patient and/or parent and the nurse verbally informs the patient/parent of the benefits of the ImmTrac Registry

Step 19) Based on the patient/parent's decision and the data/documents entered by the Front Desk and Immunizations Registration Nurse, the Vaccine Nurse selects one of the following options which ties into the associated forms:

- Patient has ImmTrac consent on file (Vaccine consent only triggered to print on page—see Sample IMM #1 in Attachment B)
- Patient DOES NOT have an ImmTrac consent on file and wishes to participate in the program (Vaccine consent and ImmTrac consent triggered to print on one page—see Sample IMM #2 in Attachment B)
- Patient DOES NOT have an ImmTrac consent on file and DOES NOT wish to participate in the program at this time (same as Sample IMM #1 in Attachment B, but with a notation that states "The ImmTrac Program has been explained to me and I choose NOT to participate in it at this time")

Step 20) Vaccine Nurse then selects the option to create the Vaccine/ImmTrac Consent form based on a template with the patient's demographics and vaccine information automatically populated

Step 21) Patient/Parent signs the consent for the vaccine administration either by use of signature pad (desired) or signing a paper copy of the consent form

- Vaccine nurse would need the option to save the Vaccine/ImmTrac Consent form into the EMRS or check a box that indicates the Vaccine/ImmTrac Consent form will be scanned in later
- If the option to scan in later is chosen, it would be desirable for a tickler report to automatically generate to identify missing Vaccine/ImmTrac Consent forms to ensure the completeness of the EMRS record

IMMUNIZATIONS DIRECT PATIENT CARE (Page 3)

Step 22) Vaccine Nurse enters any future reminder dates in a “Reminder Date” section of the EMRS which can be queried and activated for future automatic patient reminder notifications based on patient’s selected method of notification (USPS mail, email, or phone notification)

Step 23) Once the vaccine information, reminder dates and Vaccine/ImmTrac Consent information have been entered, the Vaccine Nurse administers the vaccination and selects an option to save the record and either:

- A) send the patient to the “Checkout Queue” for the Front Desk
- B) send the patient to another clinic’s queue; however, the EMRS would need to bypass the registration queue and going directly to the queue for the nursing staff where the patient then completes the next clinic’s process

Step 24) Patient/Parent goes to the Front Desk where the vaccine selections made previously by the Vaccine Nurse have tied into various Front Desk payment/check out processes such as:

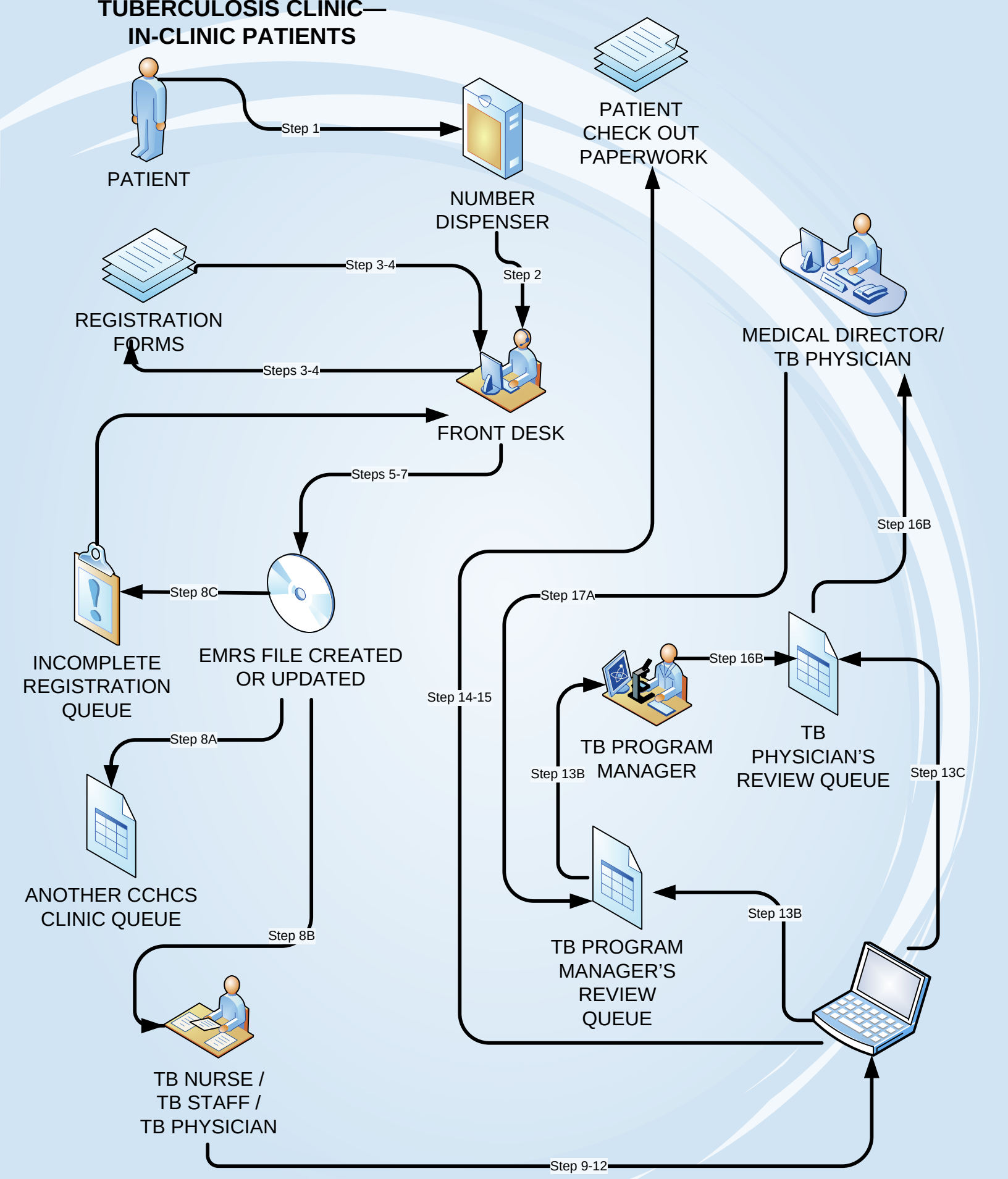
- generating fees for payment and receipts
- generating an updated Immunization Record (based on template loaded into EMRS and populated with EMRS patient and vaccine data)
- attaching the correct language Vaccine Information Sheet for patient education; the default language for patients will be English and in most cases, alternate language forms will be pre-loaded in a report writer or PDF as a template with the EMRS filling in patient identifying information.

Step 25) Based on the information entered by the Vaccine Nurse in EMRS, the patient submits payment to the Front Desk staff member in cash, check, credit card, or paid by grant funds (no cost to patient)

Step 26) Once all necessary steps are completed, the Front Desk staff member electronically marks the patient visit as ‘completed’, prints out payment receipt, updated immunization record with reminder dates printed on it, and VIS information in the patient’s language of choice using templates made by CCHCS

Collin County Health Care Services Direct Patient Care Workflows

TUBERCULOSIS CLINIC— IN-CLINIC PATIENTS



TUBERCULOSIS CLINIC (IN-CLINIC PATIENTS); DIRECT PATIENT CARE (Page1)

The TB clinic does not wish to use a queue process for managing the flow of patients from registration through checkout in the same manner as other clinics. Rather, the following features outlined in the steps below are highly desired of the EMRS for the TB Clinic Staff: Also, because the TB Clinic is receives the patient's information prior to their arrival at the clinic from outside agencies, the EMRS should allow the TB nurses to create an EMRS file and schedule the patient's first appointment (See TB Case Investigation Workflow) using the EMRS appointment scheduler.

Step 1) Patient takes a number from the CCHCS lobby area and Front Desk staff calls the patient's number in order for patient to receive any Registration forms and/or paperwork needed for their visit which was not already entered by the TB Nurse prior to their arrival

Step 2) All patient forms are stored as templates with digital barcodes in EMRS and staff is able to print blank forms individually or en masse for patients to fill out/keep as the need arises; once forms are completed by the patient and scanned, EMRS also needs to provide dynamic indexing (i.e. areas of the record are linked to the barcode printed—the scanned Patient History form is stored under the "Patient History" tab/folder/section of the patient's EMRS record, the scanned Immunization Screening Questionnaire is stored under the "Immunizations tab/folder/section of the patient's EMRS record, etc…):

- Patient Registration forms
- Patient Health History
- Existing Immunization Record; In the event the patient did not bring their immunization record, a copy of it may be also be accessed by Front Desk staff members by signing on to the TWICES or ImmTrac secure websites and printing the screen to a template with a digital barcode which can be printed, scanned, and saved into the patient's EMRS record)
- Immunization Screening Questionnaire
- Notice of Privacy Practices (for patient to keep)
- Acknowledgment of Receipt of Notice of Privacy Practices
- Patient's picture/electronic signature captured and/or saved

Step 3) Patient fills out and turns in paper forms to Front Desk Staff for data entry/scanning.

Step 4) Front Desk staff need desktop duplex color scanners to scan the forms mentioned above into the patient's EMRS record as individual PDF's which are automatically saved with a date/time stamp under the file location associated with the barcode on the form

Step 5) Front Desk staff member searches the EMRS to see if the patient already exists.

- If the patient is a new patient, the Front Desk Staff member 'creates' a new patient EMRS file
- If the patient's file already exists, the Front Desk staff member reviews and/or edits the patient's information as needed

Step 6) Front Desk staff members enters/updates the following data into the EMRS if not already completed by the TB Nurse prior to the patient's visit:

- Patient Demographics
- Contact Information including preferred method of contact (phone, email, USPS mail)
- Financial/Insurance/Information (Of note, the EMRS needs to have an option to identify whether the patient is 1) a Collin County employee or dependent, or 2) a State employee or dependent, or 3) general public, since payment/billing will be tied into these profiles
- Reason for Visit (option to check boxes and have a general comments box—see document labeled "Fee Schedule" in Attachment B); boxes checked can trigger payment required

Step 7) Front Desk staff member:

- reviews/acts on any special instructions and system-generated messages regarding additional appointments needed and/or missing information; System features should include checks which restrict the user from going to the next screen/step unless certain fields have been completed
- is flagged to collect a payment based on fee schedule; patient submits payment to the Front Desk staff member in cash, check, credit card; patient is given receipt for payment

TUBERCULOSIS CLINIC (IN-CLINIC PATIENTS); DIRECT PATIENT CARE (Page 2)

Step 8) Once the patient file is created and/or updates are saved, the Front Desk staff member will call the TB staff to notify them of the TB patient's arrival and then can choose to:

- A) mark the patient as checked in and place the patient into additional CCHCS Queue(s) based on the time the patient's information was completed if they need services from another clinic in addition to the TB Clinic, or
- B) save the patient's file without transferring to the direct patient care workflow if they are only being seen by the TB Clinic staff or
- C) placing the patient in an "Incomplete Registration Queue" in instances where a patient is missing a document for registration but still needs to be monitored; for example, the patient forgets to bring their immunization record and their primary care physician is faxing the document, we want to make sure the patient is not 'forgotten' while they are waiting for the document to be faxed to the nursing staff
- If choosing option B or C, there should be an added security prompt to ensure that the end user doesn't accidentally misroute the patient
- Of note, since patients frequently request services from more than one clinic, it is desirable for patients to be able to be placed in multiple queues so that they can be seen by the first available clinic; also staff members need to be able to have a clear alert when the patient has requested services from multiple clinics so that they can be transferred to the next clinic's queue seamlessly
- CCHCS staff should be able to view the queues to their respective clinics based on the user's security access in order to provide customer feedback on wait times as well as to manage staff resources

Step 9) TB Nurse or TB Staff member directs patient into examination room. TB Nurse or TB Staff member has a computer/notebook/laptop which they can access the patient's EMRS file. The patient's EMRS file is divided into the following 'tabs'/page views:

- DSHS TB 400A form
- DSHS TB 400B form
- DSHS TB 340 form
- DSHS TB 202 form
- DSHS TB 203 form
- DSHS TB 205 form
- Physician Progress Notes/ Nursing Notes
- Consults
- Health History
- Sputums
- Radiology
- Serology
- Directly Observed Therapy (DOT) medications/calendars
- Prior medical records
- Non Medical Information (Contact Investigation)--****It is critical that the EMRS have the ability to 'hide' the content on this tab/page in the instance where the patient's record needs to be emailed or faxed to an outside agency; it is desirable that an administrative override/password be required in order to export this information to an outside source******

Step 10) The TB Nurse or TB Staff members discusses their visit with the patient and may have the TB Physician meet with the patient for evaluation, medication, and or treatment needs

Step 11) The TB Physician evaluates the patient, discusses reason for visit, provides needed treatment, and updates the patient's EMRS file as needed; the EMRS also allows the TB Physician to use checklists in order to enter/modify/clarify the scanned patient history information (i.e., allergies, medications, medical conditions, etc…)

Step 12) The TB Nurse, TB Staff member, and TB Physician can enter/update information on any one tab while preserving the ability of other staff members to access the same record and view/enter/update other tabs

Step 13) At the bottom of each tab/page view, the TB Nurse/TB Staff member/TB Physician has the option to:

- A) Save the EMRS record updates/information entered without sending to a queue for review
- B) Save the EMRS record updates/information and send to the "TB Program Manager's Review Queue"; Refer to Step 16
- C) Save the EMRS record updates/information and send to the "TB Physician's Review Queue"

Step 14) The TB Nurse, TB Staff member, and/or TB Physician uses EMRS tools to generate and print any form letter, patient education, prescription, referral letter, or other document for patient use, or use by another department/outside agency based on templates developed by CCHCS (the ability to stamp/attach a digital signature on these types of documents is highly desired)

TUBERCULOSIS CLINIC (IN-CLINIC PATIENTS); DIRECT PATIENT CARE (Page 3)

Step 15) Once the visit is concluded, the TB Nurse/TB Staff Member/TB Physician directs the patient to the exit without needing to go to the Front Desk for a checkout process

Step 16) From their review page, the TB Program Manager has the option to either:

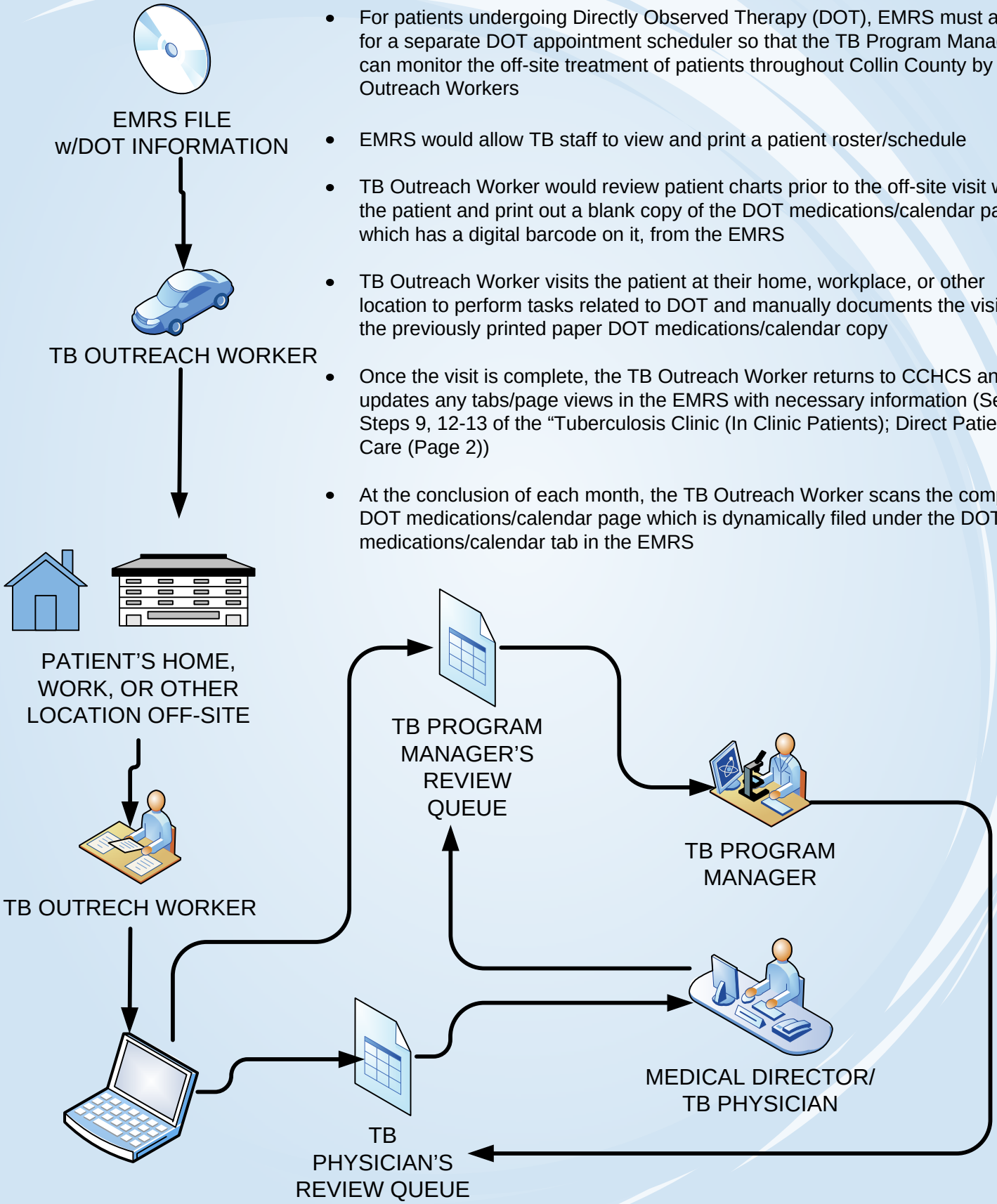
- A) Save the EMRS record updates/information entered without sending to a queue for review
- B) Save the EMRS record updates/information and send to the “TB Physician’s Review Queue”; Refer to Step 17

Step 17) TB Physician/Medical Director has the option to:

- A) Review/edit/update the EMRS and marks the patient’s file as “Review Incomplete” which places the patient’s EMRS record back into the “TB Program Manager’s Assistant Review Queue”
- B) Review/edit/update the EMRS and marks the patient’s file as “Review Complete” which closes out the patient’s visit

Collin County Health Care Services Direct Patient Care Workflows

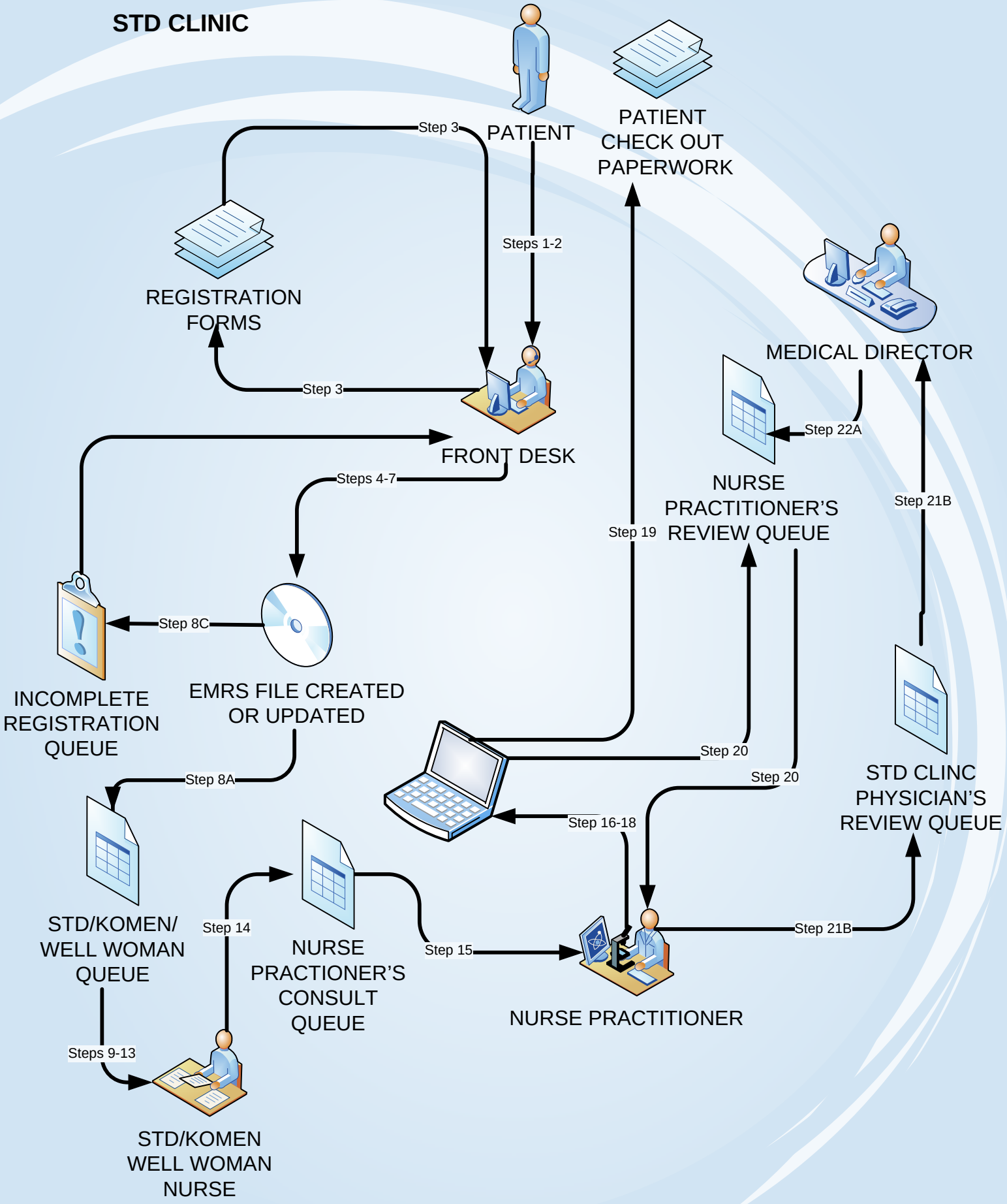
TUBERCULOSIS CLINIC— DOT PATIENTS



- For patients undergoing Directly Observed Therapy (DOT), EMRS must allow for a separate DOT appointment scheduler so that the TB Program Manager can monitor the off-site treatment of patients throughout Collin County by TB Outreach Workers
- EMRS would allow TB staff to view and print a patient roster/schedule
- TB Outreach Worker would review patient charts prior to the off-site visit with the patient and print out a blank copy of the DOT medications/calendar page, which has a digital barcode on it, from the EMRS
- TB Outreach Worker visits the patient at their home, workplace, or other location to perform tasks related to DOT and manually documents the visits on the previously printed paper DOT medications/calendar copy
- Once the visit is complete, the TB Outreach Worker returns to CCHCS and updates any tabs/page views in the EMRS with necessary information (See Steps 9, 12-13 of the "Tuberculosis Clinic (In Clinic Patients); Direct Patient Care (Page 2))
- At the conclusion of each month, the TB Outreach Worker scans the completed DOT medications/calendar page which is dynamically filed under the DOT medications/calendar tab in the EMRS

Collin County Health Care Services Direct Patient Care Workflows

STD CLINIC



STD CLINIC DIRECT PATIENT CARE (Page 1)

Step 1) Patient takes a number from the CCHCS lobby area and Front Desk staff calls the patient's number in order for patient to receive the Registration forms and paperwork needed for their visit

Step 2) All patient forms are stored as templates with digital barcodes in EMRS and staff is able to print blank forms individually or en masse for patients to fill out/keep as the need arises; once forms are completed by the patient and scanned, EMRS also needs to provide dynamic indexing (i.e. areas of the record are linked to the barcode printed—the scanned Patient History form is stored under the "Patient History" tab/folder/section of the patient's EMRS record, the scanned Immunization Screening Questionnaire is stored under the "Immunizations tab/folder/section of the patient's EMRS record, etc…):

- Patient Registration forms
- Patient Health History
- Existing Immunization Record; In the event the patient did not bring their immunization record, a copy of it may be also be accessed by Front Desk staff members by signing on to the TWICES or ImmTrac secure websites and printing the screen to a template with a digital barcode which can be printed, scanned, and saved into the patient's EMRS record)
- Immunization Screening Questionnaire
- Notice of Privacy Practices (for patient to keep)
- Acknowledgment of Receipt of Notice of Privacy Practices
- Patient's picture/electronic signature captured and/or saved

Step 3) Patient fills out and turns in paper forms to Front Desk Staff for data entry/scanning.

Step 4) Front Desk staff need desktop duplex color scanners to scan the forms mentioned above into the patient's EMRS record as individual PDF's which are automatically saved with a date/time stamp under the file location associated with the barcode on the form

Step 5) Front Desk staff member searches the EMRS to see if the patient already exists.

- If the patient is a new patient, the Front Desk Staff member 'creates' a new patient EMRS file
- If the patient's file already exists, the Front Desk staff member reviews and/or edits the patient's information as needed

Step 6) Front Desk staff members enters/updates the following data into the EMRS:

- Patient Demographics
- Contact Information including preferred method of contact (phone, email, USPS mail)
- Financial/Insurance/Information (Of note, the EMRS needs to have an option to identify whether the patient is 1) a Collin County employee or dependent, or 2) a State employee or dependent, or 3) general public, since payment/billing will be tied into these profiles
- Reason for Visit (option to check boxes and have a general comments box—see document labeled "Fee Schedule" in Attachment B); boxes checked can trigger payment required

Step 7) Front Desk staff member:

- reviews/acts on any special instructions and system-generated messages regarding additional appointments needed and/or missing information; System features should include checks which restrict the user from going to the next screen/step unless certain fields have been completed
- is flagged to collect payment based on fee schedule; patient submits payment to the Front Desk staff member in cash, check, credit card; patient is given receipt

Step 8) Once the patient file is created and/or updates are saved, the Front Desk staff member can choose to:

- A) mark the patient as checked in and place the patient into the "STD/Komen/Well Woman Queue" based on the time the patient's information was completed or
- B) save the patient's file without transferring to the direct patient care workflow or
- C) placing the patient in an "Incomplete Registration Queue" in instances where a patient is missing a document for registration but still needs to be monitored; for example, the patient forgets to bring their immunization record and their primary care physician is faxing the document, we want to make sure the patient is not 'forgotten' while they are waiting for the document to be faxed to the nursing staff

STD CLINIC DIRECT PATIENT CARE (Page 2)

Step 8) continued

- If choosing option B or C, there should be an added security prompt to ensure that the end user doesn't accidentally misroute the patient
- Of note, since patients frequently request services from more than one clinic, it is desirable for patients to be able to be placed in multiple queues so that they can be seen by the first available clinic; also staff members need to be able to have a clear alert when the patient has requested services from multiple clinics so that they can be transferred to the next clinic's queue seamlessly
- CCHCS staff should be able to view the queues to their respective clinics based on the user's security access in order to provide customer feedback on wait times as well as to manage staff resources

Step 9) STD/Komen/Well Woman Nurse has a computer/notebook/laptop which is 'activated' to receive patients once the nurse signs into it; It is important that the computer/notebook/laptop can be connected to an additional monitor so that the nurse can view the EMRS on one screen and additional document/sites on the second screen

Step 10) EMRS sends the information of the next patient in line in the STD/Komen/Well Woman queue to an available STD/Komen/Well Woman Nurse's computer

Step 11) The patient's information, scanned documents, color-coded elapsed wait time, and reason for visit are displayed on the STD/Komen/Well Woman Nurse's notebook/laptop

Step 12) STD/Komen/Well Woman Nurse directs patient into an examination room

Step 13) STD/Komen/Well Woman Nurse accesses patient's EMRS file and updates/enters/reviews essential information such as: current vital signs, lab results, progress notes, current medications, changes in health history, etc…

Step 14) Once the patient is ready to be seen by the Nurse Practitioner, the STD/Komen/Well Woman Nurse has the option to save the file and transfer the patient to the "Nurse Practitioner's Consult Queue"

Step 15) Nurse Practitioner has a laptop/notebook with the same features as listed above and the EMRS sends the information of the next patient in line in the STD/Komen/Well Woman Queue to her computer

Step 16) Nurse Practitioner evaluates the patient, discusses reason for visit, provides needed treatment, and updates the patient's EMRS file as needed; the EMRS also allows the Nurse Practitioner to use checklists in order to enter/modify/clarify the scanned patient history information (i.e., allergies, medications, medical conditions, etc…)

Step 17) Nurse Practitioner uses EMRS tools to generate any form letter, prescription, referral letter, or other document for patient use, or use by another department/outside agency based on templates developed by CCHCS (the ability to stamp/attach a digital signature on these types of documents is highly desired)

Step 18) Nurse Practitioner enters any future reminder dates in a "Reminder Date" section of the EMRS which can be queried and activated for future automatic patient reminder notifications based on patient's selected method of notification (USPS mail, email, or phone notification). The information will be printed as a "Reminder" during the checkout process at the front desk

Step 19) Nurse Practitioner processes/prints any receipt/prescription/letters/forms/paperwork/discharge instructions for the patient.

- If the patient has follow-up appointments scheduled in the EMRS at this time, the reminder will be labeled on the discharge paperwork as "Scheduled Appointment" and the "Reminder Date(s)" entered by the Nurse Practitioner will not show
- If the patient does not have a follow-up appointment, the "Reminder Date(s)" will be labeled as "Remember to Contact Us to Set Up an Appointment For" on the discharge paperwork
- EMRS will send out phone/email/mail reminder based on preferences entered in the registration process prior to patient's next appointment

Step 20) Once all necessary steps are completed, the Nurse Practitioner electronically marks the patient visit as 'completed' which places the patient's EMRS record into the "Nurse Practitioner's Review Queue" for chart review

Step 21) Nurse Practitioner has the option to either:

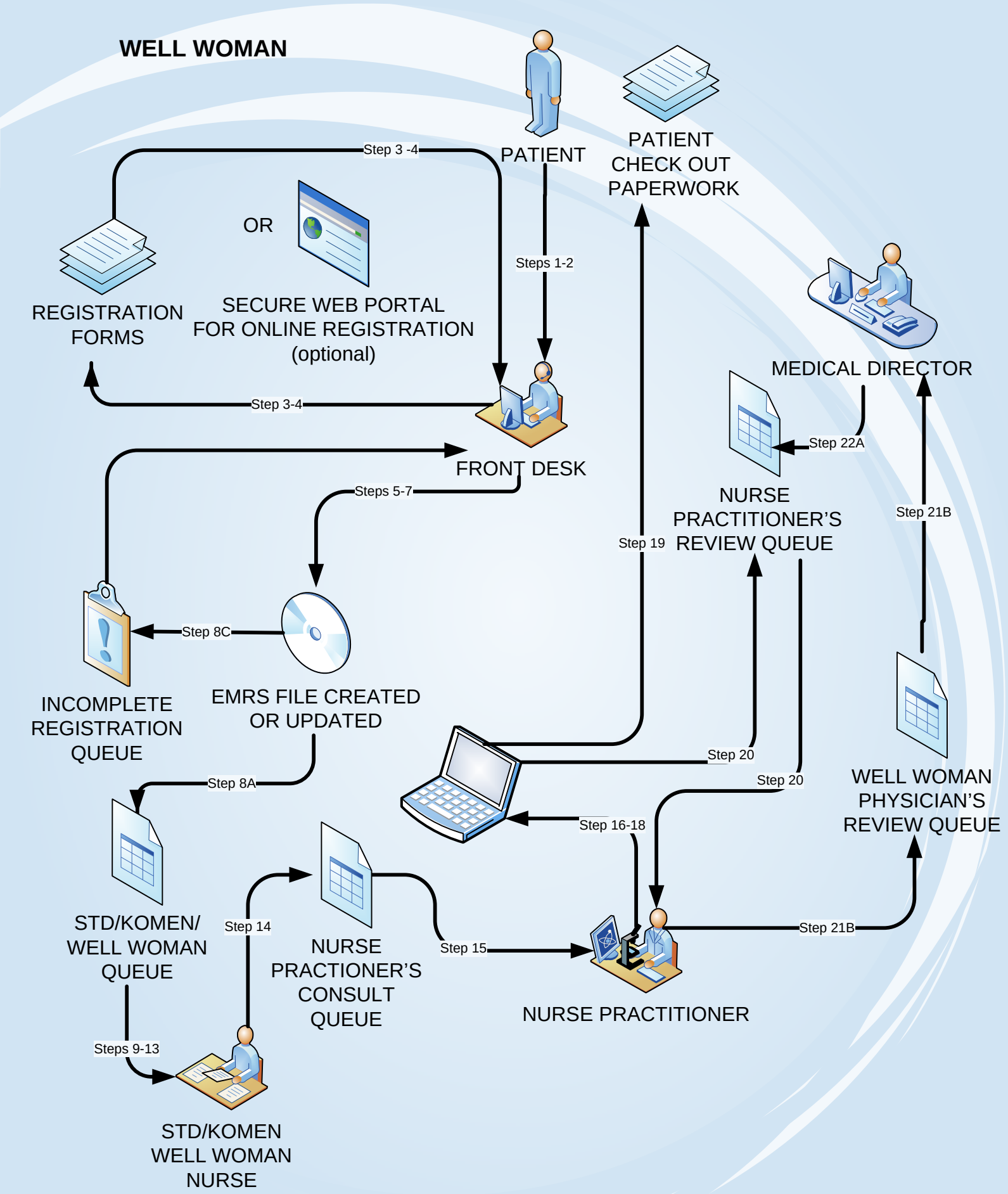
- A) Save the EMRS file without transferring to another queue or
- B) Review/edit/update the EMRS, and transfer the patient's file to the "STD Clinic Physician's Review Queue" for final review and completion from the Medical Director

STD CLINIC DIRECT PATIENT CARE (Page 3)

Step 22) Medical Director has the option to:

- A) Review/edit/update the EMRS and marks the patient's file as "Review Incomplete" which places the patient's EMRS record back into the "Nurse Practitioner's Review Queue"
- B) Review/edit/update the EMRS and marks the patient's file as "Review Complete" which closes out the patient's visit

Collin County Health Care Services Direct Patient Care Workflows



WELL WOMAN CLINIC DIRECT PATIENT CARE (Page 1)

Step 1) Patient calls CCHCS for an appointment with or walks into the Employee Health Entrance at CCHCS for a Well Woman visit and Front Desk staff calls the patient name in order for either 1) patient to receive the Registration forms and paperwork needed for their visit or 2) for Front Desk staff member to review Patient Registration forms submitted online for accuracy/completeness

Step 2) All patient forms are stored as templates with digital barcodes in EMRS and staff is able to print blank forms individually or en masse for patients to fill out/keep as the need arises; once forms are completed by the patient and scanned, EMRS also needs to provide dynamic indexing (i.e. areas of the patient's EMRS record are linked to the barcode printed on the form—the scanned Patient History form is stored under the "Patient History" tab/folder/section of the record, the scanned Immunization Screening Questionnaire is stored under the "Immunizations" tab/folder/section of the patient's EMRS record, etc…):

- Patient Registration Forms
- Patient Health History
- Existing Immunization Record; In the event the patient did not bring their immunization record, a copy of it may be also be accessed by Front Desk staff members by signing on to the TWICES or ImmTrac secure websites and printing the screen to a template with a digital barcode which can be printed, scanned, and saved into the patient's EMRS record)
- Immunization Screening Questionnaire
- Notice of Privacy Practices (for patient to keep)
- Acknowledgment of Receipt of Notice of Privacy Practices
- Patient's picture/electronic signature captured and/or saved

Step 3) Patient fills out and turns in any necessary paper forms to Front Desk Staff for data entry and scanning.

Step 4) **For paper documents filled out in person:**

- Front Desk staff need desktop duplex color scanners to scan the forms mentioned above into the patient's EMRS record as individual PDF's which are automatically saved with a date/time stamp under the file location associated with the printed barcode on the form

For documents filled out online, the EMRS needs to:

- allow for the Front Desk staff member to print the documents on paper with a digital barcode and a date/time stamp so that patient's can sign them
- the Front Desk staff member then scans the document so the PDF image is automatically filed under the location associated with the barcode on the form

Step 5) Front Desk staff member searches the EMRS to see if the patient already exists.

- If the patient is a new patient, the Front Desk Staff member 'creates' a new patient EMRS file
- If the patient's file already exists, the Front Desk staff member reviews and/or edits the patient's information as needed

Step 6) Front Desk staff members enters/updated the following data into the EMRS:

- Patient Demographics
- Contact Information including preferred method of contact (phone, email, USPS mail)
- Financial/Insurance/Information (Of note, the EMRS needs to have an option to identify whether the patient is 1) a Collin County employee or dependent, or 2) a State employee or dependent, or 3) general public, since payment/billing will be tied into these profiles
- Reason for Visit (option to check boxes and have a general comments box—see document labeled "Fee Schedule" in Attachment B); boxes checked can trigger payment required

Step 7) Front Desk staff member:

- reviews/acts on any special instructions and system-generated messages regarding additional appointments needed and/or missing information; System features should include checks which restrict the user from going to the next screen/step unless certain fields have been completed
- is flagged to collect a co-pay only in instances where the patient is a State Employee; patient submits payment to the Front Desk staff member in cash, check, credit card

WELL WOMAN CLINIC DIRECT PATIENT CARE (Page 2)

Step 8) Next, the Front Desk staff member can choose to:

- A) mark the patient as checked in and place the patient into the "STD/Komen/Well Woman Queue" based on the time the patient's information was completed or
- B) save the patient's file without transferring to the direct patient care workflow or
- C) placing the patient in an "Incomplete Registration Queue" in instances where a patient is missing a document for registration but still needs to be monitored; for example, the patient forgets to bring their immunization record and their primary care physician is faxing the document, we want to make sure the patient is not 'forgotten' while they are waiting for the document to be faxed to the nursing staff
- If choosing option B or C, there should be an added security prompt to ensure that the end user doesn't accidentally misroute the patient
- Of note, since patients frequently request services from more than one clinic, it is desirable for patients to be able to be placed in multiple queues so that they can be seen by the first available clinic; also staff members need to be able to have a clear alert when the patient has requested services from multiple clinics so that they can be transferred to the next clinic's queue seamlessly
- CCHCS staff should be able to view the queues to their respective clinics based on the user's security access in order to provide customer feedback on wait times as well as to manage staff resources

Step 9) STD/Komen/Well Woman Nurse has a computer/notebook/laptop which is 'activated' to receive patients once the nurse signs into it; It is important that the computer/notebook/laptop can be connected to an additional monitor so that the nurse can view the EMRS on one screen and additional document/sites on the second screen

Step 10) EMRS sends the information of the next patient in line in the STD/Komen/Well Woman queue to an available STD/Komen/Well Woman Nurse's computer

Step 11) The patient's information, scanned documents, color-coded elapsed wait time, and reason for visit are displayed on the STD/Komen/Well Woman Nurse's notebook/laptop

Step 12) STD/Komen/Well Woman Nurse directs patient into an examination room

Step 13) STD/Komen/Well Woman Nurse accesses patient's EMRS file and updates/enters/reviews essential information such as: current vital signs, lab results, progress notes, current medications, changes in health history, etc…

Step 14) Once the patient is ready to be seen by the Nurse Practitioner, the STD/Komen/Well Woman Nurse has the option to save the file and transfer the patient to the "Nurse Practitioner's Consult Queue"

Step 15) Nurse Practitioner has a laptop/notebook with the same features as listed above and the EMRS sends the information of the next patient in line in the STD/Komen/Well Woman Queue to her computer

Step 16) Nurse Practitioner evaluates the patient, discusses reason for visit, provides needed treatment, and updates the patient's EMRS file as needed; the EMRS also allows the Nurse Practitioner to use checklists in order to enter/modify/clarify the scanned patient history information (i.e., allergies, medications, medical conditions, etc…)

Step 17) Nurse Practitioner uses EMRS tools to generate any form letter, prescription, referral letter, or other document for patient use, or use by another department/outside agency based on templates developed by CCHCS (the ability to stamp/attach a digital signature on these types of documents is highly desired)

Step 18) Nurse Practitioner enters any future reminder dates in a "Reminder Date" section of the EMRS which can be queried and activated for future automatic patient reminder notifications based on patient's selected method of notification (USPS mail, email, or phone notification). The information will be printed as a "Reminder" during the checkout process at the front desk

Step 19) Nurse Practitioner processes/prints any receipt/prescription/letters/forms/paperwork/discharge instructions for the patient.

- If the patient has follow-up appointments scheduled in the EMRS at this time, the reminder will be labeled on the discharge paperwork as "Scheduled Appointment" and the "Reminder Date(s)" entered by the Nurse Practitioner will not show
- If the patient does not have a follow-up appointment, the "Reminder Date(s)" will be labeled as "Remember to Contact Us to Set Up an Appointment For" on the discharge paperwork

WELL WOMAN CLINIC DIRECT PATIENT CARE (Page 3)

Step 19) continued

- EMRS will send out phone/email/mail reminder based on preferences entered in the registration process prior to patient's next appointment

Step 20) Once all necessary steps are completed, the Nurse Practitioner electronically marks the patient visit as 'completed' which places the patient's EMRS record into the "Nurse Practitioner's Review Queue" for chart review

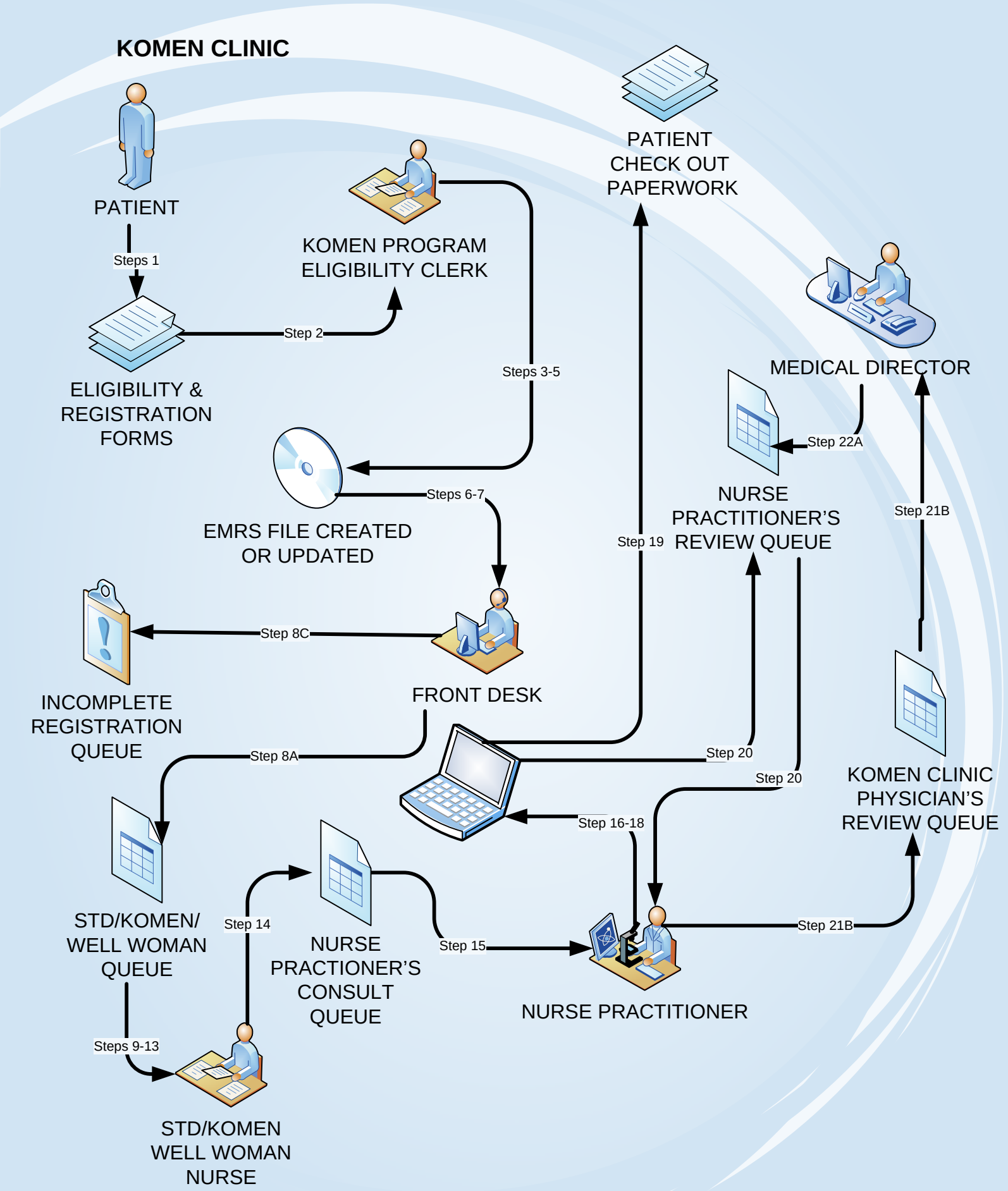
Step 21) Nurse Practitioner has the option to either:

- A) Save the EMRS file without transferring to another queue or
- B) Review/edit/update the EMRS, and transfer the patient's file to the "Well Woman Physician's Review Queue" for final review and completion from the Medical Director

Step 22) Medical Director has the option to:

- A) Review/edit/update the EMRS and marks the patient's file as "Review Incomplete" which places the patient's EMRS record back into the "Nurse Practitioner's Review Queue"
- B) Review/edit/update the EMRS and marks the patient's file as "Review Complete" which closes out the patient's visit

Collin County Health Care Services Direct Patient Care Workflows



KOMEN CLINIC DIRECT PATIENT CARE (Page 1)

Step 1) Patient contacts CCHCS for services provided through the Komen Clinic and patient is mailed/given the eligibility and registration forms to complete and return. All patient forms are stored as templates with digital barcodes in EMRS and staff is able to print blank forms individually or en masse for patients to fill out/keep as the need arises; once forms are completed by the patient and scanned, EMRS also needs to provide dynamic indexing (i.e. areas of the record are linked to the barcode printed—the scanned Patient History form is stored under the "Patient History" tab/folder/section of the patient's EMRS record, the scanned Immunization Screening Questionnaire is stored under the "Immunizations tab/folder/section of the patient's EMRS record, etc…):

- Patient Registration forms
- Patient Health History
- Existing Immunization Record; In the event the patient did not bring their immunization record, a copy of it may be also be accessed by Front Desk staff members by signing on to the TWICES or ImmTrac secure websites and printing the screen to a template with a digital barcode which can be printed, scanned, and saved into the patient's EMRS record)
- Immunization Screening Questionnaire
- Notice of Privacy Practices (for patient to keep)
- Acknowledgment of Receipt of Notice of Privacy Practices

Step 2) Patient returns eligibility and registration forms to the Komen Eligibility Clerk for review

Step 3) Komen Eligibility Clerk member searches the EMRS to see if the patient already exists.

- If the patient is a new patient, the Komen Eligibility Clerk 'creates' a new patient EMRS file
- If the patient's file already exists, the Komen Eligibility Clerk reviews and/or edits the patient's information as needed

Step 4) Komen Eligibility Clerk enters/updates the following data into the EMRS:

- Patient Demographics and patient's picture/electronic signature captured and/or saved
- Contact Information including preferred method of contact (phone, email, USPS mail)
- Financial/Insurance/Information (Of note, the EMRS needs to have an option to identify whether the patient is 1) a Collin County employee or dependent, or 2) a State employee or dependent, or 3) general public, since payment/billing will be tied into these profiles
- Reason for Visit (option to check boxes and have a general comments box—see document labeled "Fee Schedule" in Attachment B); boxes checked can trigger payment required

Step 5) If the patient qualifies for the program, the Komen Eligibility Clerk needs a desktop duplex color scanner to scan the forms mentioned above into the patient's EMRS record as individual PDF's which are automatically saved with a date/time stamp under the file location associated with the barcode on the form

Step 6) Komen Eligibility Clerk contacts the patient and schedules their first appointment in the EMRS and instructs the patient to go to the CCHCS Front Desk for their appointment check in

Step 7) Once the patient arrives at the CCHCS Front Desk, the Front Desk staff member searches for and locates the patient's EMRS record and :

- reviews/acts on any special instructions and system-generated messages regarding additional appointments needed and/or missing information; System features should include checks which restrict the user from going to the next screen/step unless certain fields have been completed
- is flagged to collect payment based on fee schedule; patient submits payment to the Front Desk staff member in cash, check, credit card; patient is given receipt

Step 8) Then Front Desk staff member can choose to:

- A) mark the patient as checked in and place the patient into the "STD/Komen/Well Woman Queue" based on the time the patient's information was completed or
- B) save the patient's file without transferring to the direct patient care workflow or
- C) placing the patient in an "Incomplete Registration Queue" in instances where a patient is missing a document for registration but still needs to be monitored; for example, the patient forgets to bring their immunization record and their primary care physician is faxing the document, we want to make sure the patient is not 'forgotten' while they are waiting for the document to be faxed to the nursing staff

KOMEN CLINIC DIRECT PATIENT CARE (Page 2)

Step 8) continued

- If choosing option B or C, there should be an added security prompt to ensure that the end user doesn't accidentally misroute the patient
- Of note, since patients frequently request services from more than one clinic, it is desirable for patients to be able to be placed in multiple queues so that they can be seen by the first available clinic; also staff members need to be able to have a clear alert when the patient has requested services from multiple clinics so that they can be transferred to the next clinic's queue seamlessly
- CCHCS staff should be able to view the queues to their respective clinics based on the user's security access in order to provide customer feedback on wait times as well as to manage staff resources

Step 9) STD/Komen/Well Woman Nurse has a computer/notebook/laptop which is 'activated' to receive patients once the nurse signs into it; It is important that the computer/notebook/laptop can be connected to an additional monitor so that the nurse can view the EMRS on one screen and additional document/sites on the second screen

Step 10) EMRS sends the information of the next patient in line in the STD/Komen/Well Woman queue to an available STD/Komen/Well Woman Nurse's computer

Step 11) The patient's information, scanned documents, color-coded elapsed wait time, and reason for visit are displayed on the STD/Komen/Well Woman Nurse's notebook/laptop

Step 12) STD/Komen/Well Woman Nurse directs patient into an examination room

Step 13) STD/Komen/Well Woman Nurse accesses patient's EMRS file and updates/enters/reviews essential information such as: current vital signs, lab results, progress notes, current medications, changes in health history, etc…

Step 14) Once the patient is ready to be seen by the Nurse Practitioner, the STD/Komen/Well Woman Nurse has the option to save the file and transfer the patient to the "Nurse Practitioner's Consult Queue"

Step 15) Nurse Practitioner has a laptop/notebook with the same features as listed above and the EMRS sends the information of the next patient in line in the STD/Komen/Well Woman Queue to her computer

Step 16) Nurse Practitioner evaluates the patient, discusses reason for visit, provides needed treatment, and updates the patient's EMRS file as needed; the EMRS also allows the Nurse Practitioner to use checklists in order to enter/modify/clarify the scanned patient history information (i.e., allergies, medications, medical conditions, etc…)

Step 17) Nurse Practitioner uses EMRS tools to generate any form letter, prescription, referral letter, or other document for patient use, or use by another department/outside agency based on templates developed by CCHCS (the ability to stamp/attach a digital signature on these types of documents is highly desired)

Step 18) Nurse Practitioner enters any future reminder dates in a "Reminder Date" section of the EMRS which can be queried and activated for future automatic patient reminder notifications based on patient's selected method of notification (USPS mail, email, or phone notification). The information will be printed as a "Reminder" during the checkout process at the front desk

Step 19) Nurse Practitioner processes/prints any receipt/prescription/letters/forms/paperwork/discharge instructions for the patient.

- If the patient has follow-up appointments scheduled in the EMRS at this time, the reminder will be labeled on the discharge paperwork as "Scheduled Appointment" and the "Reminder Date(s)" entered by the Nurse Practitioner will not show
- If the patient does not have a follow-up appointment, the "Reminder Date(s)" will be labeled as "Remember to Contact Us to Set Up an Appointment For" on the discharge paperwork
- EMRS will send out phone/email/mail reminder based on preferences entered in the registration process prior to patient's next appointment

Step 20) Once all necessary steps are completed, the Nurse Practitioner electronically marks the patient visit as 'completed' which places the patient's EMRS record into the "Nurse Practitioner's Review Queue" for chart review

Step 21) Nurse Practitioner has the option to either:

- A) Save the EMRS file without transferring to another queue or
- B) Review/edit/update the EMRS, and transfer the patient's file to the "Komen Clinic Physician's Review Queue" for final review and completion from the Medical Director

KOMEN CLINIC DIRECT PATIENT CARE (Page 3)

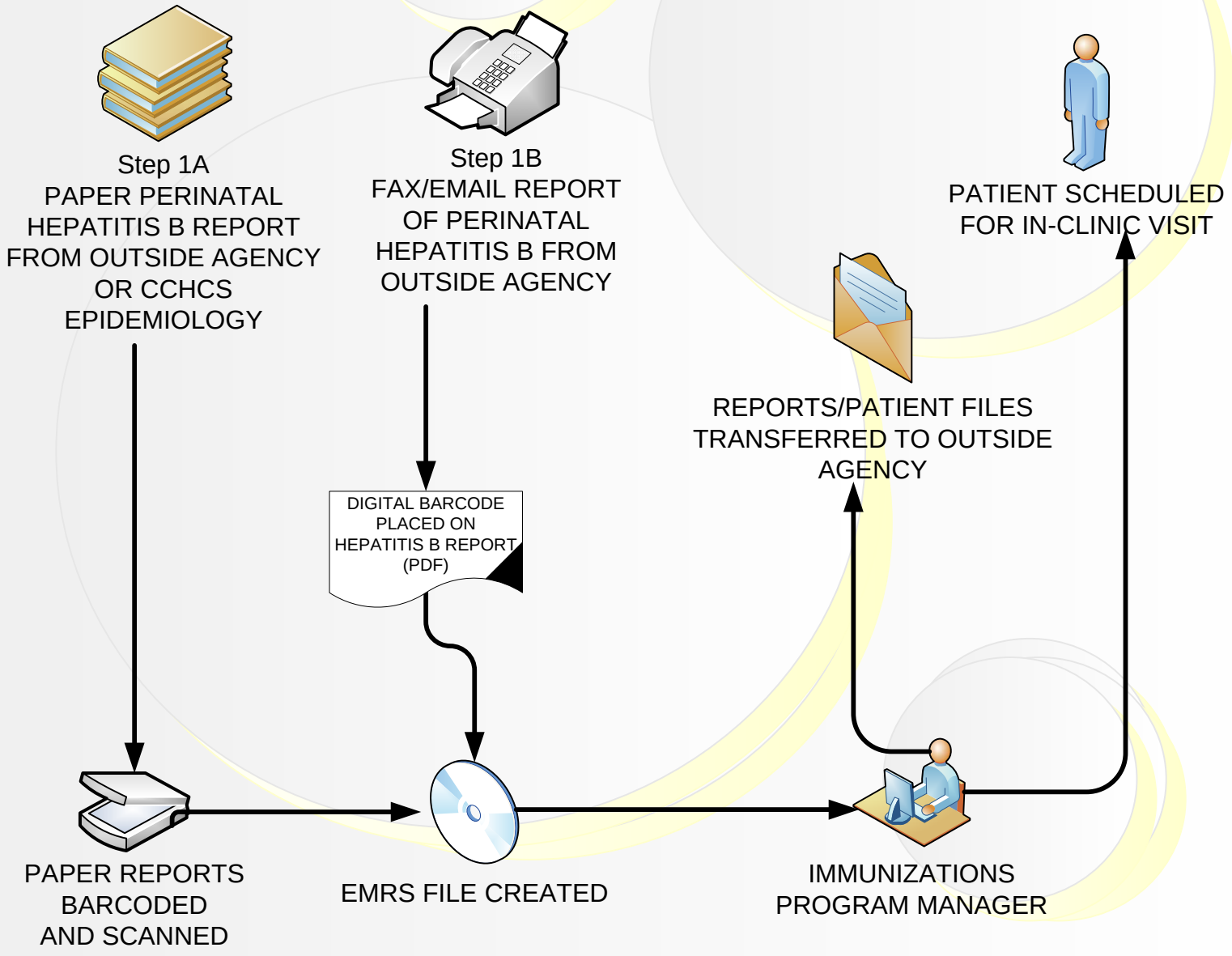
Step 22) Medical Director has the option to:

- A) Review/edit/update the EMRS and marks the patient's file as "Review Incomplete" which places the patient's EMRS record back into the "Nurse Practitioner's Review Queue"
- B) Review/edit/update the EMRS and marks the patient's file as "Review Complete" which closes out the patient's visit

Collin County Health Care Services Internal Workflows Related to Public Health

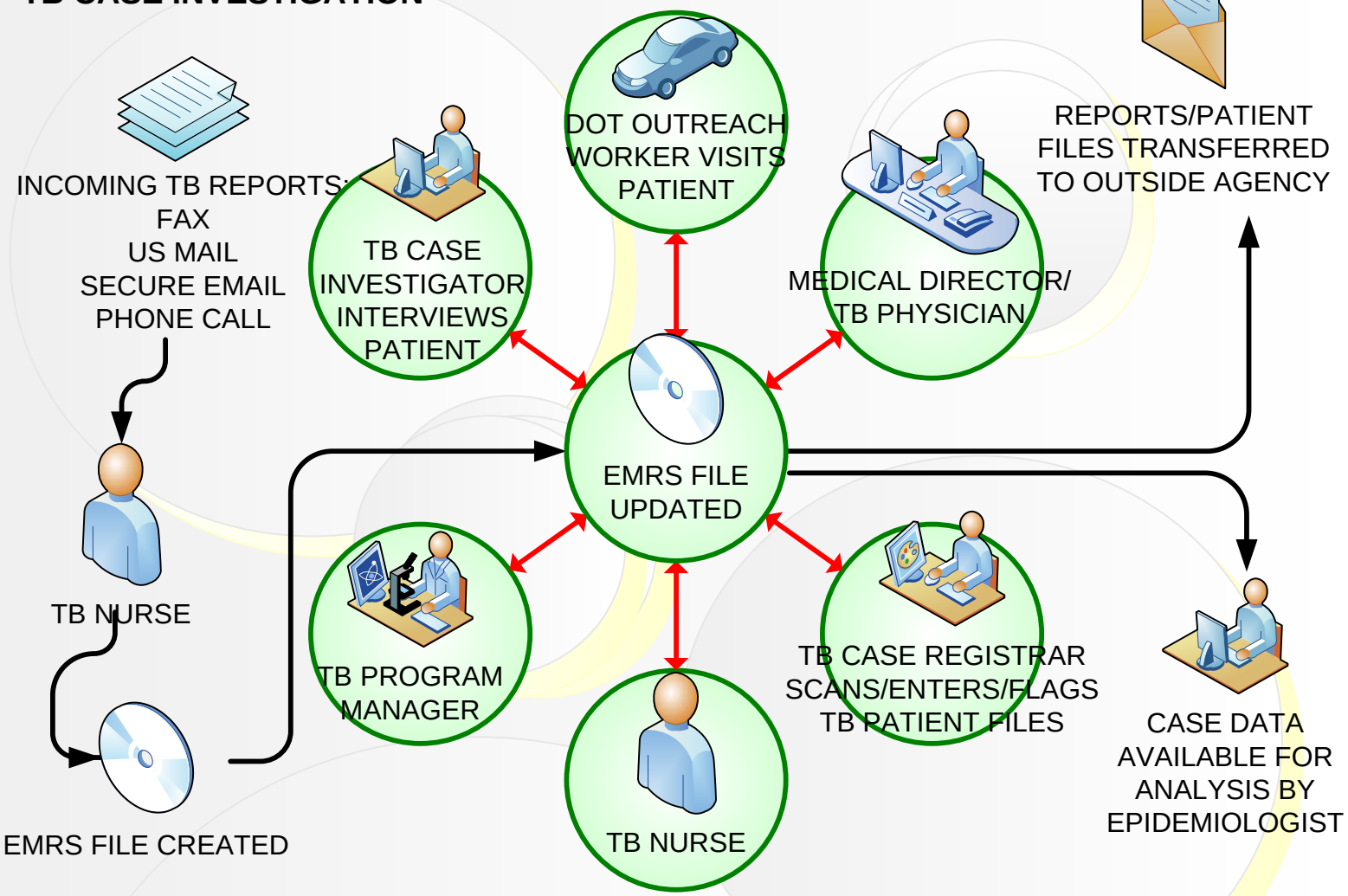
IMMUNIZATIONS CLINIC

- Step 1--Reports of pregnant women who have tested positive for Hepatitis B and their at-risk infants are sent to the Immunizations Program Manager who creates a new EMRS record by processing information received in one of two ways:
  - A) paper copies of lab reports/discharge summaries directly sent to Immunizations Program Manager who barcodes, scans and/or enters patient data from paper records into the EMRS such as: demographics, lab results, due date, infant information, prenatal care, etc...for data capture and future extraction
  - B) electronic files (fax/email) directly sent to Immunizations Program Manager who enters the same patient information as listed above from the file into the EMRS and converts the electronic file into a PDF format and stamps the document with a digital barcode which allows the user the option to save it to the correct tab/section of the patient's record
- Immunizations Program Managers uses EMRS tools to schedule appointments for patients needing to follow up with Hepatitis B vaccinations for their children
- EMRS provides Immunizations Program Manager with tools to extract patient information for reporting to Texas Department of State Health Services on templates developed by CCHCS
- EMRS allows for transferring of patient record to outside agencies in a secure/encrypted email format that is HIPAA compliant



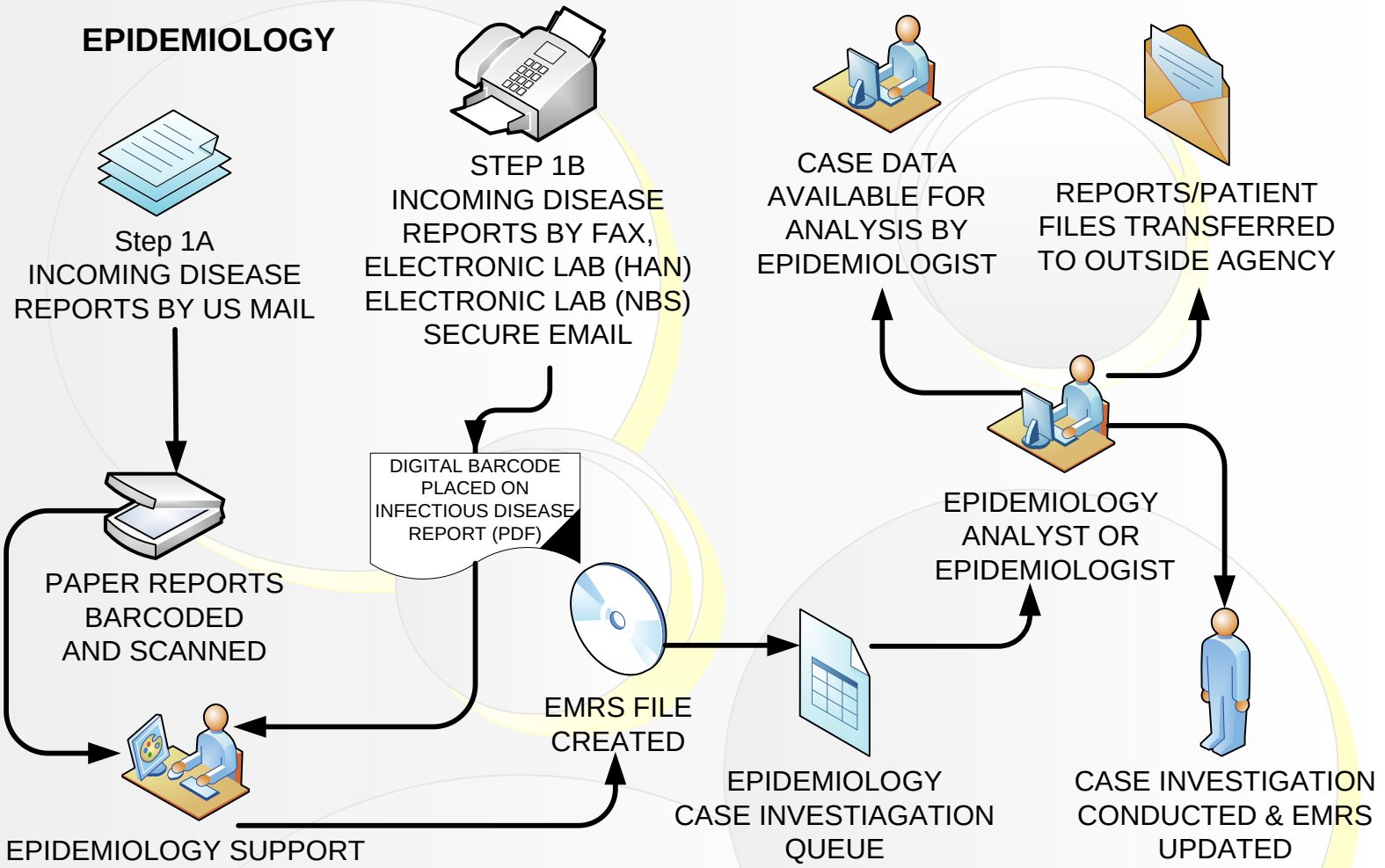
Collin County Health Care Services Internal Workflows Related to Public Health

TB CASE INVESTIGATION



- TB Nurse receives incoming TB reports from outside agencies as well as those reported to CCHCS Epidemiology
- TB Nurse enters patient demographics, lab results, etc… in to EMRS in order to create new patient file; TB Nurse also schedules patient in-clinic visit and future DOT visits as needed
- Once the patient's EMRS file is created, all TB staff members need to have the ability to allow multiple users to access and update the patient's EMRS file tabs/sections/page views simultaneously
- Throughout the following tasks, the TB staff members update the EMRS as follows:
  --TB Case Investigator contacts patient for TB case investigation and enters patient data as well as creating new EMRS files for new patients who are identified as TB contacts who need evaluation and treatment at the TB Clinic
  --TB Physician, TB Program Manager, and TB Nurses document evaluation, treatment, medication, consultations and other patient information into EMRS during patient visits to the CCHCS TB Clinic
  --TB DOT Outreach Workers document medication dispensed on hard copy forms that are scanned into EMRS
  --All TB staff have the option of sending the patient file to either the "TB Program Manager's Queue" or "TB Physician's Review Queue" for chart review (see CCHCS Direct Patient Care Workflow, Tuberculosis Clinic (In Clinic Patients), page 2, steps 9-17
- Linking patients together or cross-referencing patients based on information gathered on DSHS TB forms (TB 202 "Tuberculosis History", TB 340, TB 341 etc..) is critical in order to monitor and analyze for contact investigations
- EMRS must allow for patient data to be transferred onto state reporting forms so the forms are exactly duplicated; state reporting forms are currently available in MS Word and PDF formats and can be found at http://www.dshs.state.tx.us/idcu/disease/tb/forms/
- EMRS must allows for transferring of patient record to outside agencies (state health departments, physicians, hospitals, etc…) as needed in a secure/encrypted email format that is HIPAA compliant
- EMRS must be able to restrict the contact investigation tab/section/page view from being exported unless an administrative override/password is entered
- EMRS needs to have reporting tools for analyzing patient data for the TB Program Manager, Epidemiologist, and Medical Director in order to monitor patient treatment and case investigation progress, identify disease trends, monitor productivity of staff members, and generate reports for local and state agencies

Collin County Health Care Services Internal Workflows Related to Public Health



- Step 1—Reports of Infectious Disease are sent to and processed by the Epidemiology team in one of two ways in order to create new patient EMRS files:
  A) paper copies of lab reports/disease reports are mailed directly to CCHCS and the Epidemiology Support team member enters patient data from paper report such as lab results, patient demographics, etc...for data capture and future extraction, barcodes the record, and scans it into the EMRS
  B) electronic files (fax/email/electronic labs) are accessed by the Epidemiology Support team member who converts the electronic file into a PDF format and stamps the document with a digital barcode which allows the user the option to save the document to the correct tab/section/page view of the patient's record
- Epidemiology Support team member has the option to:
  A) electronically transfer the report to the "Epidemiology Case Investigation Queue" for case investigation by the Epidemiology Analyst or Epidemiologist
  B) or mark the case as 'completed' and save the record
- Epidemiology Analyst/Epidemiologist access the "Epidemiology Case Investigation Queue" and are able to assign the EMRS files to staff members in order to monitor cases that are unassigned, cases that are assigned/not complete, and completed cases
- Epidemiology Analyst/Epidemiologist contacts the patient and performs a disease investigation and enters the data collected into the EMRS to ultimately be able to be populate and print onto either CCHCS disease investigation forms or DSHS disease investigation forms (depending on type of disease) as needed; DSHS disease investigation forms can be found at http://www.dshs.state.tx.us/idcu/investigation/
- Once the patient's file is updated and marked as 'completed', the Epidemiology team uses EMRS tools to print out the CCHCS/DSHS disease investigation form in the event that it needs to be printed, faxed and/or mailed to another agency as part of Texas Disease Reporting laws and DSHS procedures
- EMRS allows for transferring of patient record to outside agencies in a secure/encrypted email format that is HIPAA compliant
- All case information stored in EMRS needs to be available for analysis by Epidemiologist in order to identify disease trends, monitor productivity of staff members, and generate reports for local and state agencies

Attachment K: Collin County Terms and Conditions

C O L L I N C O U N T Y, T E X A S
TERMS AND CONDITIONS

1.0 GENERAL INSTRUCTIONS

1.0.1 Definitions

1.0.1.1 Bidder/Quoter/Offeror: refers to submitter.

1.0.1.2 Vendor/Contractor/Provider: refers to a Successful Bidder/Quoter/Contractor/Service Provider.

1.0.1.3 Submittal: refers to those documents required to be submitted to Collin County, by a Bidder/Quoter/Offeror.

1.0.1.4 IFB: refers to Invitation For Bid.

1.0.1.5 RFQ: refers to Request For Quotation.

1.0.1.6 RFP: refers to Request For Proposal.

1.0.1.7 RFI: refers to Request For Information.

1.1 If Bidder/Quoter/Offeror does not wish to submit an offer at this time, please submit a No Bid Form.

1.2 Awards shall be made not more than one hundred and eighty (180) days after the time set for opening of submittals.

1.3 Collin County is always conscious and extremely appreciative of your time and effort in preparing your submittal.

1.4 Collin County exclusively uses BidSync for the notification and dissemination of all solicitations. The receipt of solicitations through any other company may result in your receipt of incomplete specifications and/or addendums which could ultimately render your bid non-compliant. Collin County accepts no responsibility for the receipt and/or notification of solicitations through any other company.

1.5 A bid/quote/submittal may not be withdrawn or canceled by the bidder/quoter/offeror prior to the ninety-first (91st) day following public opening of submittals and only prior to award.

1.6 It is understood that Collin County, Texas reserves the right to accept or reject any and/or all Bids/Quotes/Proposals/Submittals for any or all products and/or services covered in an

Invitation For Bid (IFB), Request For Quotation (RFQ), Request For Proposal (RFP) and Request For Information (RFI) and to waive informalities or defects in submittals or to accept such submittals as it shall deem to be in the best interest of Collin County.

1.7 All IFB's, RFP's, RFQ's and RFI's submitted in hard copy paper form shall be submitted in a sealed envelope, plainly marked on the outside with the IFB/RFP/RFQ/RFI number and name. A hard copy paper form submittal shall be manually signed in ink by a person having the authority to bind the firm in a contract. Submittals shall be mailed or hand delivered to the Collin County Purchasing Department.

1.8 No oral, telegraphic or telephonic submittals will be accepted. IFB's, RFP's, RFQ's and RFI's may be submitted in electronic format via BidSync.

1.9 All Invitation For Bids (IFB), Request For Proposals (RFP), Request For Quotes (RFQ), Request For Information (RFI) submitted electronically via BidSync shall remain locked until official date and time of opening as stated in the Special Terms and Conditions of the IFB, RFP, RFQ and/or RFI.

1.10 Time/date stamp clock in Collin County Purchasing Department shall be the official time of receipt for all Invitation For Bids (IFB), Request For Proposals (RFP), Request For Quotes (RFQ), Request For Information (RFI) submitted in hard copy paper form. IFB's, RFP's, RFQ's, RFI's received in County Purchasing Department after submission deadline shall be considered void and unacceptable. Absolutely no late submittals will be considered. Collin County accepts no responsibility for technical difficulties related to electronic submittals.

1.11 For hard copy paper form submittals, any alterations made prior to opening date and time must be initialed by the signer of the IFB/RFQ/RFP/RFI, guaranteeing authenticity. Submittals cannot be altered or amended after submission deadline.

1.12 Collin County is by statute exempt from the State Sales Tax and Federal Excise Tax; therefore, the prices submitted shall not include taxes.

1.13 Any interpretations, corrections and/or changes to an Invitation For Bid/Request For Quotation/Request For Proposal/Request for Information and related Specifications or extensions to the opening/receipt date will be made by addenda to the respective document by the Collin County Purchasing Department. Questions and/or clarification requests must be submitted no later than seven (7) days prior to the opening/receipt date. Those received at a later date may not be addressed prior to the public opening. Sole authority to authorize addenda shall be vested in Collin County Purchasing Agent as entrusted by the Collin County Commissioners' Court. Addenda may be transmitted electronically via BidSync, by facsimile, E-mail transmission or mailed via the US Postal Service.

1.13.1 Addenda will be transmitted to all that are known to have received a copy of the IFB/RFQ/RFP/RFI and related Specifications. However, it shall be the sole responsibility of the Bidder/Quoter/Offeror to verify issuance/non-issuance of addenda and to check all avenues of document availability (i.e. BidSync www.bidsync.com ,

telephoning Purchasing Department directly, etc.) prior to opening/receipt date and time to insure Bidder/Quoter/Offeror's receipt of any addenda issued. Bidder/Quoter/Offeror shall acknowledge receipt of all addenda.

1.14 All materials and services shall be subject to Collin County approval.

1.15 Collin County reserves the right to make award in whole or in part as it deems to be in the best interest of the County.

1.16 The Bidder/Quoter/Offeror shall comply with Commissioners' Court Order No. 96-680-10-28, Establishment of Guidelines & Restrictions Regarding the Acceptance of Gifts by County Officials & County Employees.

1.17 Any reference to model/make and/or manufacturer used in specifications is for descriptive purposes only. Products/materials of like quality will be considered.

1.18 Bidders/Quoters/Offerors taking exception to the specifications shall do so at their own risk. By offering substitutions, Bidder/Quoter/Offeror shall state these exceptions in the section provided in the IFB/RFQ/RFP or by attachment. Exception/substitution, if accepted, must meet or exceed specifications stated therein. Collin County reserves the right to accept or reject any and/or all of the exception(s)/substitution(s) deemed to be in the best interest of the County.

1.19 Minimum Standards for Responsible Prospective Bidders/Quoters/Offerors: A prospective Bidder/ Quoter/Offeror must meet the following minimum requirements:

1.19.1 have adequate financial resources, or the ability to obtain such resources as required;

1.19.2 be able to comply with the required or proposed delivery/completion schedule;

1.19.3 have a satisfactory record of performance;

1.19.4 have a satisfactory record of integrity and ethics;

1.19.5 be otherwise qualified and eligible to receive an award.

Collin County may request documentation and other information sufficient to determine Bidder's/Quoter's/ Offeror's ability to meet these minimum standards listed above.

1.20 Vendor shall bear any/all costs associated with it's preparation of an RFI/IFB/RFQ/RFP submittal.

1.21 Public Information Act: Collin County is governed by the Texas Public Information Act, Chapter 552 of the Texas Government Code. All information submitted by prospective bidders during the bidding process is subject to release under the Act.

Attachment K: Collin County Terms and Conditions

1.22 The Bidder/Quoter/Offeror shall comply with Commissioners' Court Order No. 2004-167-03-11, County Logo Policy.

1.23 Interlocal Agreement: Successful bidder agrees to extend prices and terms to all entities that has entered into or will enter into joint purchasing interlocal cooperation agreements with Collin County.

1.24 Bid Openings: All bids submitted will be read at the county's regularly scheduled bid opening for the designated project. However, the reading of a bid at bid opening should be not construed as a comment on the responsiveness of such bid or as any indication that the county accepts such bid as responsive.

The county will make a determination as to the responsiveness of bids submitted based upon compliance with all applicable laws, Collin County Purchasing Guidelines, and project documents, including but not limited to the project specifications and contract documents. The county will notify the successful bidder upon award of the contract and, according to state law; all bids received will be available for inspection at that time.

2.0 TERMS OF CONTRACT

2.1 A bid/quote/proposal, when properly accepted by Collin County, shall constitute a contract equally binding between the Vendor/Contractor/Provider and Collin County. No different or additional terms will become part of this contract with the exception of an Amendment and/or a Change Order.

2.2 No oral statement of any person shall modify or otherwise change, or affect the terms, conditions or specifications stated in the resulting contract. All Amendments and/or Change Orders to the contract will be made in writing by Collin County Purchasing Agent.

2.3 No public official shall have interest in the contract, in accordance with Vernon's Texas Codes Annotated, Local Government Code Title 5, Subtitle C, Chapter 171.

2.4 The Vendor/Contractor/Provider shall comply with Commissioners' Court Order No. 96-680-10-28, Establishment of Guidelines & Restrictions Regarding the Acceptance of Gifts by County Officials & County Employees.

2.5 Design, strength, quality of materials and workmanship must conform to the highest standards of manufacturing and engineering practice.

2.6 Bids/Quotes/Proposals must comply with all federal, state, county and local laws concerning the type(s) of product(s)/service(s)/equipment/project(s) contracted for, and the fulfillment of all ADA (Americans with Disabilities Act) requirements.

2.7 All products must be new and unused, unless otherwise specified, in first-class condition and of current manufacture. Obsolete products, including products or any parts not compatible with existing hardware/software configurations will not be accepted.

2.8 Vendor/Contractor/Provider shall provide any and all notices as may be required under the Drug-Free Work Place Act of 1988, 28 CFR Part 67, Subpart F, to its employees and all sub-contractors to insure that Collin County maintains a drug-free work place.

2.9 Vendor/Contractor/Provider shall defend, indemnify and save harmless Collin County and all its officers, agents and employees and all entities, their officers, agents and employees who are participating in this contract from all suits, claims, actions, damages (including personal injury and or property damages), or demands of any character, name and description, (including attorneys' fees, expenses and other defense costs of any nature) brought for or on account of any injuries or damages received or sustained by any person, persons, or property on account of Vendor/Contractor/Provider's breach of the contract arising from an award, and/or any negligent act, error, omission or fault of the Vendor/Contractor/Provider, or of any agent, employee, subcontractor or supplier of Vendor/Contractor/Provider in the execution of, or performance under, any contract which may result from an award. Vendor/Contractor/Provider shall pay in full any judgment with costs, including attorneys' fees and expenses which are rendered against Collin County and/or participating entities arising out of such breach, act, error, omission and/or fault.

2.10 If a contract, resulting from a Collin County IFB, RFP, RFQ, is for the execution of a public work, the following shall apply:

2.10.1 In accordance with V.T.C.A. 2253.021, a governmental agency that makes a public work contract with a prime contractor shall require the contractor, before beginning work, to execute to the governmental entity a Payment Bond if the contract is in excess of $25,000.00. Such bond shall be in the amount of the contract payable to the governmental entity and must be executed by a corporate surety in accordance with Section 1, Chapter 87, Acts of the 56th Legislature, Regular Session, 1959 (Article 7.19-1 Vernon's Texas Insurance Code).

2.10.2 In accordance with V.T.C.A. 2253.021, a governmental agency that makes a public work contract with a prime contractor shall require the contractor, before beginning work, to execute to the governmental entity a Performance Bond if the contract is in excess of $100,000.00. Such bond shall be in the amount of the contract payable to the governmental entity and must be executed by a corporate surety in accordance with Section 1, Chapter 87, Acts of the 56th Legislature, Regular Session, 1959 (Article 7.19-1 Vernon's Texas Insurance Code).

2.11 Purchase Order(s) shall be generated by Collin County to the vendor. Collin County will not be responsible for any orders placed/delivered without a valid purchase order number.

2.12 The contract shall remain in effect until any of the following occurs: delivery of product(s) and/or completion and acceptance by Collin County of product(s) and/or service(s),

contract expires or is terminated by either party with thirty (30) days written notice prior to cancellation and notice must state therein the reasons for such cancellation. Collin County reserves the right to terminate the contract immediately in the event the Vendor/Contractor/Provider fails to meet delivery or completion schedules, or otherwise perform in accordance with the specifications. Breach of contract or default authorizes the County to purchase elsewhere and charge the full increase in cost and handling to the defaulting Vendor/Contractor/Provider.

2.13 Collin County Purchasing Department shall serve as Contract Administrator or shall supervise agents designated by Collin County.

2.14 All delivery and freight charges (FOB Inside delivery at Collin County designated locations) are to be included as part of the bid/quote/proposal price. All components required to render the item complete, installed and operational shall be included in the total bid/quote/proposal price. Collin County will pay no additional freight/delivery/installation/setup fees.

2.15 Vendor/Contractor/Provider shall notify the Purchasing Department immediately if delivery/completion schedule cannot be met. If delay is foreseen, the Vendor/Contractor/Provider shall give written notice to the Purchasing Agent. The County has the right to extend delivery/completion time if reason appears valid.

2.16 The title and risk of loss of the product(s) shall not pass to Collin County until Collin County actually receives and takes possession of the product(s) at the point or points of delivery. Collin County shall generate a purchase order(s) to the Vendor/Contractor/Provider and the purchase order number must appear on all itemized invoices.

2.17 Invoices shall be mailed directly to the Collin County Auditor's Office, Sixth Floor, Collin County Courthouse, 200 South McDonald Street, Suite 300, McKinney, Texas 75069. All invoices shall show:

2.17.1 Collin County Purchase Order Number;

2.17.2 Vendor’s/Contractor’s/Provider’s Name, Address and Tax Identification Number;

2.17.3 Detailed breakdown of all charges for the product(s) and/or service(s) including applicable time frames.

2.18 Payment will be made in accordance with V.T.C.A., Government Code, Title 10, Subtitle F, Chapter 2251.

2.19 All warranties shall be stated as required in the Uniform Commercial Code.

2.20 The Vendor/Contractor/Provider and Collin County agree that both parties have all rights, duties, and remedies available as stated in the Uniform Commercial Code.

2.21 The Vendor/Contractor/Provider agree to protect Collin County from any claims involving infringements of patents and/or copyrights.

2.22 The contract will be governed by the laws of the State of Texas. Should any portion of the contract be in conflict with the laws of the State of Texas, the State laws shall invalidate only that portion. The remaining portion of the contract shall remain in effect. The contract is performable in Collin County, Texas.

2.23 The Vendor/Contractor/Provider shall not sell, assign, transfer or convey the contract, in whole or in part, without the prior written approval from Collin County.

2.24 The apparent silence of any part of the specification as to any detail or to the apparent omission from it of a detailed description concerning any point, shall be regarded as meaning that only the best commercial practices are to prevail. All interpretations of the specification shall be made on the basis of this statement.

2.25 Vendor/Contractor/Provider shall not fraudulently advertise, publish or otherwise make reference to the existence of a contract between Collin County and Vendor/Contractor/Provider for purposes of solicitation. As exception, Vendor/Contractor/Provider may refer to Collin County as an evaluating reference for purposes of establishing a contract with other entities.

2.26 The Vendor/Contractor/Provider understands, acknowledges and agrees that if the Vendor/Contractor/Provider subcontracts with a third party for services and/or material, the primary Vendor/Contractor/Provider (awardee) accepts responsibility for full and prompt payment to the third party. Any dispute between the primary Vendor/Contractor/Provider and the third party, including any payment dispute, will be promptly remedied by the primary vendor. Failure to promptly render a remedy or to make prompt payment to the third party (subcontractor) may result in the withholding of funds from the primary Vendor/Contractor/Provider by Collin County for any payments owed to the third party.

2.27 Vendor/Contractor/Provider shall provide Collin County with diagnostic access tools at no additional cost to Collin County, for all Electrical and Mechanical systems, components, etc., procured through this contract.

2.28 Criminal History Background Check: If required, ALL individuals may be subject to a criminal history background check performed by the Collin County's Sheriff's Office prior to access being granted to Collin County. Upon request, Vendor/Contractor/Provider shall provide list of individuals to Collin County Purchasing Department within five (5) working days.

2.29 Non-Disclosure Agreement: Where applicable, vendor shall be required to sign a non-disclosure agreement acknowledging that all information to be furnished is in all respects confidential in nature, other than information which is in the public domain through other means and that any disclosure or use of same by vendor, except as provided in the contract/agreement, may cause serious harm or damage to Collin County. Therefore, Vendor agrees that Vendor will not use the information furnished for any purpose other than that stated in contract/agreement, and agrees that Vendor will not either directly or indirectly by agent, employee, or representative

disclose this information, either in whole or in part, to any third party, except on a need to know basis for the purpose of evaluating any possible transaction. This agreement shall be binding upon Collin County and Vendor, and upon the directors, officers, employees and agents of each.

2.30 Vendors/Contractors/Providers must be in compliance with the Immigration and Reform Act of 1986 and all employees specific to this solicitation must be legally eligible to work in the United States of America.

2.31 Certification of Eligibility: This provision applies if the anticipated Contract exceeds $100,000.00 and as it relates to the expenditure of federal grant funds. By submitting a bid or proposal in response to this solicitation, the Bidder/Quoter/Offeror certifies that at the time of submission, he/she is not on the Federal Government's list of suspended, ineligible, or debarred contractors. In the event of placement on the list between the time of bid/proposal submission and time of award, the Bidder/Quoter/Offeror will notify the Collin County Purchasing Agent. Failure to do so may result in terminating this contract for default.

2.32 Notice to Vendors/Contractors/Providers delivering goods or performing services within the Collin County Detention Facility: The Collin County Detention Facility houses persons who have been charged with and/or convicted of serious criminal offenses. When entering the Detention Facility, you could: (1) hear obscene or graphic language; (2) view partially clothed male inmates; (3) be subjected to verbal abuse or taunting; (4) risk physical altercations or physical contact, which could be minimal or possibly serious; (5) be exposed to communicable or infectious diseases; (6) be temporarily detained or prevented from immediately leaving the Detention Facility in the case of an emergency or "lockdown"; and (7) subjected to a search of your person or property. While the Collin County Sheriff's Office takes every reasonable precaution to protect the safety of visitors to the Detention Facility, because of the inherently dangerous nature of a Detention Facility and the type of the persons incarcerated therein, please be advised of the possibility of such situations exist and you should carefully consider such risks when entering the Detention Facility. By entering the Collin County Detention Facility, you acknowledge that you are aware of such potential risks and willingly and knowingly choose to enter the Collin County Detention Facility.

2.33 Delays and Extensions of Time when applicable:

2.33.1 If the Vendor/Contractor/Provider is delayed at any time in the commence or progress of the Work by an act or neglect of the Owner or Architect/Engineer, or of an employee of either, or of a separate contractor employed by the Owner, or by changes ordered in the Work, or by labor disputes, fire, unusual delay in deliveries, unavoidable casualties or other causes beyond the Vendor/Contractor/Provider's control, or by delay authorized by the Owner pending mediation and arbitration, or by other causes which the Owner or Architect/Engineer determines may justify delay, then the Contract Time shall be extended by Change Order for such reasonable time as the Owner/Architect may determine.

2.33.2 If adverse weather conditions are the basis for a Claim for additional time, such Claim shall be documented by data substantiating that weather conditions were abnormal for the period of time and could not have been reasonably anticipated, and that the weather conditions had an adverse effect on the scheduled construction.

NOTE: All other terms and conditions (i.e. Insurance Requirements, Bond Requirements, etc.) shall be stated in the individual IFB/RFQ/RFP/RFI Solicitation documents as Special Terms, Conditions and Specifications.

Attachment K: Collin County Terms and Conditions

SIGNATURE FORM
COLLIN COUNTY, TEXAS

DELIVERY WILL BE F.O.B. INSIDE DELIVERY AT COLLIN COUNTY DESIGNATED LOCATIONS AND ALL TRANSPORTATION CHARGES PAID BY THE SUPPLIER TO DESTINATION.

DELIVERY TO BE SPECIFIED IN CALENDAR DAYS FROM DATE OF ORDER.

WE **DO NOT** TAKE EXCEPTION TO THE BID SPECIFICATIONS.

WE **TAKE** EXCEPTION TO THE BID SPECIFICATIONS (EXPLAIN):

COMPANY INFORMATION/PROFILE/REFERENCES
Preferential Requirement: The County of Collin, as a governmental agency of the State of Texas, may not award a contract to a nonresident bidder unless the nonresident's bid is lower than the lowest bid submitted by a responsible Texas resident bidder by the same amount that a Texas resident bidder would be required to underbid a nonresident bidder to obtain a comparable contract in the state in which the nonresident's principal place of business is located (Government Code, Title 10, V.T.C.A., Chapter 2252, Subchapter A). Bidder shall make answer to the following questions by selecting the appropriate radio button or inserting information in the box provided:

Is your principal place of business in the State of Texas? Yes No

If the answer to question is "yes", no further information is necessary; if "no", please indicate:

in which state is your principal place of business is located:

if that state favors resident bidders (bidders in your state) by some dollar increment or percentage: Yes No

if "yes", what is that dollar increment or percentage?

Company Profile: IS YOUR FIRM?

Sole Proprietorship	Yes	No
General Partnership	Yes	No
Limited Partnership	Yes	No
Corporation	Yes	No
Other	Yes	No

List Legal Names in Company:

List at least three (3) companies or governmental agencies where these same/like products/services, as stated herein, have been provided. Include company name, address, contact name and telephone number.

AS PERMITTED UNDER TITLE 8, CHAPTER 271, SUBCHAPTER F, SECTION 271.101 AND 271.102 V.T.C.A. AND TITLE 7, CHAPTER 791, SUBCHAPTER C, SECTION 791.025, V.T.C.A., OTHER LOCAL GOVERNMENTAL ENTITIES MAY WISH TO ALSO PARTICIPATE UNDER THE SAME TERMS AND CONDITIONS CONTAINED IN THIS CONTRACT. EACH ENTITY WISHING TO PARTICIPATE MUST ENTER INTO AN INTERLOCAL AGREEMENT WITH COLLIN COUNTY AND HAVE PRIOR AUTHORIZATION FROM VENDOR. IF SUCH PARTICIPATION IS AUTHORIZED, ALL PURCHASE ORDERS WILL BE ISSUED DIRECTLY FROM AND SHIPPED DIRECTLY TO THE LOCAL GOVERNMENTAL ENTITY REQUIRING SUPPLIES/SERVICES. COLLIN COUNTY SHALL NOT BE HELD RESPONSIBLE FOR ANY ORDERS PLACED, DELIVERIES MADE OR PAYMENT FOR SUPPLIES/SERVICES ORDERED BY THESE ENTITIES. EACH ENTITY RESERVES THE RIGHT TO DETERMINE THEIR PARTICIPATION IN THIS CONTRACT. WOULD BIDDER BE WILLING TO ALLOW OTHER LOCAL GOVERNMENTAL ENTITIES TO PARTICIPATE IN THIS CONTRACT, IF AWARDED, UNDER THE SAME TERMS AND CONDITIONS? Yes No

By signing and submitting this Bid/Proposal, Bidder/Offeror acknowledges, understands the specifications, any and all addenda, and agrees to the bid/proposal terms and conditions and can provide the minimum requirements stated herein. Bidder/Offeror acknowledges they have read the document in its entirety, visited the site, performed investigations and verifications as deemed necessary, is familiar with local conditions under which work is to be performed and will be responsible for any and all errors in Bid/Proposal submittal resulting from Bidder/Offeror's failure to do so. Bidder/Offeror acknowledges the prices submitted in this Bid/Proposal have been carefully reviewed and are submitted as correct and final. If Bid/Proposal is accepted, vendor further certifies and agrees to furnish any and all products/services upon which prices are extended at the price submitted, and upon conditions in the specifications of the Invitation for Bid/Request for Proposal.

THE UNDERSIGNED HEREBY CERTIFIES THE FOREGOING BID/PROPOSAL SUBMITTED BY THE COMPANY LISTED BELOW HEREINAFTER CALLED "BIDDER/OFFEROR" IS THE DULY AUTHORIZED AGENT OF SAID COMPANY AND THE PERSON SIGNING SAID BID/PROPOSAL HAS BEEN DULY AUTHORIZED TO EXECUTE SAME. BIDDER/OFFEROR AFFIRMS THAT THEY ARE DULY AUTHORIZED TO EXECUTE THIS CONTRACT; THIS COMPANY; CORPORATION, FIRM, PARTNERSHIP OR INDIVIDUAL HAS NOT PREPARED THIS BID/PROPOSAL IN COLLUSION WITH ANY OTHER BIDDER/OFFEROR OR OTHER PERSON OR PERSONS ENGAGED IN THE SAME LINE OF BUSINESS; AND THAT THE CONTENTS OF THIS BID/PROPOSAL AS TO PRICES, TERMS AND CONDITIONS OF SAID BID/PROPOSAL HAVE NOT BEEN COMMUNICATED BY THE UNDERSIGNED NOR BY ANY EMPLOYEE OR AGENT TO ANY OTHER PERSON ENGAGED IN THIS TYPE OF BUSINESS PRIOR TO THE OFFICIAL OPENING OF THIS BID/PROPOSAL.

Company Name	
Street Address of Principal Place of Business	
City, State, Zip	
Phone of Principal Place of Business	
Fax of Principal Place of Business	
E-mail Address of Representative	
Federal Identification Number	
Date	
Acknowledgement of Addenda	#1 #2 #3 #4 #5 #6
Authorized Representative Name	
Authorized Representative Title	
Signature (Required for paper bid submission)	

AFFIDAVIT OF COMPLIANCE

I, the undersigned, declare and affirm that my company is in compliance with the Immigration and Reform Act of 1986 and all employees are legally eligible to work in the United States of America.

I further understand and acknowledge that any non-compliance with the Immigration and Reform Act of 1986 at any time during the term of this contract will render the contract voidable.

Name of Company	
Title of Officer	
Name of Officer	
Date:	

CONFLICT OF INTEREST QUESTIONNAIRE
FORM CIQ
For vendor or other person doing business with local governmental entity

This questionnaire is being filed in accordance with chapter 176 of the Local Government Code by a person doing business with the governmental entity.

By law this questionnaire must be filed with the records administrator of the local government not later than the 7th business day after the date the person becomes aware of facts that require the statement to be filed. *See* Section 176.006, Local Government Code.

A person commits an offense if the person violates Section 176.006, Local Government Code. An offense under this section is a Class C misdemeanor.

OFFICE USE ONLY

Date Received

1	**Name of person doing business with local governmental entity.**
2	☐ **Check this box if you are filing an update to a previously filed questionnaire.** (The law requires that you file an updated completed questionnaire with the appropriate filing authority not later than September 1 of the year for which an activity described in Section 176.006(a), Local Government Code, is pending and not later than the 7th business day after the date the originally filed questionnaire becomes incomplete or inaccurate.)
3	**Name each employee or contractor of the local governmental entity who makes recommendations to a local government officer of the governmental entity with respect to expenditures of money AND describe the affiliation or business relationship.**
4	**Name each local government officer who appoints or employs local government officers of the governmental entity for which this questionnaire is filed AND describe the affiliation or business relationship.**

Adopted 11/02/2005

FORM CIQ

CONFLICT OF INTEREST QUESTIONNAIRE

Page 2

For vendor or other person doing business with local governmental entity

5 **Name of local government officer with whom filer has affiliation or business relationship.**
(Complete this section only if the answer to A, B, or C is YES.

This section, item 5 including subparts A, B, C & D, must be completed for each officer with whom the filer has affiliation or other relationship. Attach additional pages to this Form CIQ as necessary.

A. Is the local government officer named in this section receiving or likely to receive taxable income from the filer of the questionnaire? é Yes é No

B. Is the filer of the questionnaire receiving or likely to receive taxable income from or at the direction of the local government officer named in this section AND the taxable income is not from the local governmental entity? é Yes é No

C. Is the filer of this questionnaire affiliated with a corporation or other business entity that the local government officer serves as an officer or director, or holds an ownership of 10 percent or more?
é Yes é No

D. Describe each affiliation or business relationship.

6

Signature of person doing business with the governmental entity

Date

Adopted 11/02/2005

In order to better serve our bidders, the Collin County Purchasing Department is conducting the following survey. We appreciate your time and effort expended to submit your bid. Please take a moment to complete the below. Should you have any questions or require more information please call (972) 548-4165.

HOW DID YOU RECEIVE NOTICE OF THIS REQUEST FOR BID OR PROPOSALS?

McKinney Courier-Gazette?	é	Yes	é	No
Plan Room?	é	Yes	é	No
Collin County Web-Site?	é	Yes	é	No
Facsimile or email from BidSync?	é	Yes	é	No

Other

HOW DID YOU RECEIVE THE BID DOCUMENTS?

Downloaded from Home Computer?	é	Yes	é	No
Downloaded from Company Computer?	é	Yes	é	No
Requested a Copy from Collin County?	é	Yes	é	No

Other

Thank You,

Collin County Purchasing Department

Question and Answers for Bid #12108-10 - Electronic Medical Records System

OVERALL BID QUESTIONS

There are no questions associated with this bid. If you would like to submit a question, please click on the "Create New Question" button below.