Nemaha County Community Health Services
1004 Main Street
Sabetha, KS 66534
(785) 284-2152

Tuberculosis Screening Documentation

Name of person to receive TB skin test______________________________

Date of Birth______________ Phone Number________________________

Address____________________City______________State________

Zip Code___________ Primary Physician's Name/Clinic____________________

	Question		
1.	Have you ever had a positive TB skin test before?	YES	NO
2.	Have you ever had tuberculosis?	YES	NO
3.	Has any member of your family had tuberculosis?	YES	NO
4.	Have you ever received an immunization called BCG? (A vaccine used in many parts of the world where TB is common)	YES	NO
5.	Have you had a viral infection in the last 4 weeks?	YES	NO
6.	Have you received any of the following vaccines within the last 4 weeks?		
	MMR	YES	NO
	Varicella (Chickenpox)	YES	NO
	Zoster (Shingles)	YES	NO
	Flu Mist (nasal spray)	YES	NO
	Yellow Fever	YES	NO
7.	Do you have any further questions regarding this skin test?	YES	NO

I have been offered or provided, whether accepted or not, a copy of the Nemaha County Community Health Services (NCCHS) Notice of Privacy Practices with the effective date of April 14, 2003. My questions have been answered satisfactorily, and I ask that the TB skin test be given to me or the person named above for whom I am authorized to make this request. I understand that the TB skin test must be read by a nurse employed at NCCHS. You may release this information to my physician. I agree to pay any remaining amount of my bill to NCCHS that my insurance company does not pay.

______________________________ ____________

Signature of Patient or Parent/Guardian **Date**

Date Mantoux Skin Test Administered____________ Time Administered_______AM/PM

Site Administered__________________ PPD Manufacturer________________

PPD Lot Number______________PPD Expiration Date__________________

Signature and Title of Nurse Administering__________________________

Interpretation

Date Mantoux Skin Test Read______________ Time Read___________AM/PM

Results_______mm induration Interpreter Signature and Title__________________

Check In Sheet – NEMAHA COUNTY COMMUNITY HEALTH SERVICES

Thank you for choosing Nemaha County Community Health Services. In order to serve you, we need the following information. **Please Print.** All information is confidential.

PATIENT INFORMATION				
Patient's First Name:	**Patient's Last Name:**		**Birth Date:**	**Age:**
Street Address:		**Phone Number:**		
City:	**County:**	**State:**	**Zip Code:**	
Gender: ☐ Male ☐ Female	**Primary Care Physician:**			

INSURANCE INFORMATION	
Insurance Carrier: ☐KanCare (Aetna, United Healthcare, Sunflower) ☐Medicare ☐BCBS ☐Meritain ☐SISCO ☐Aetna ☐Cigna ☐United Healthcare ☐GPHA ☐Other:______	
1. Do you have health insurance?	___yes ___no
2. Does your insurance cover immunizations?	___yes ___no
3. Does your insurance cover only select vaccines or cap vaccine costs?	___yes ___no

☐ ***Skip the following section if health insurance copy is attached.***			
Insurance Company:	**Member ID #:**	**Group #:**	
Subscriber's Name:	**Relationship to Subscriber:**	**Effective Date:**	
Insurance Company Address:	**City:**	**State:**	**Zip Code:**
Name of Employer:	**Work Phone Number:**		
Address of Employer:	**City:**	**State:**	**Zip Code:**

_______________I understand that I am financially responsible for all charges for services rendered including the balance remaining after payment of possible insurance benefits. I understand that Nemaha County Community Health Services is not responsible for notifying me in advance of non-covered services and that all non-covered services are my financial responsibility. I understand that if I am unable to pay the full amount due, I must make monthly payments until a zero balance is obtained.

- I certify that the above information is correct to the best of my knowledge.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment for the purpose of evaluating and administering claims for insurance benefits.
- I authorize release of immunization records to any school, daycare center, health department or other healthcare provider.
- I acknowledge that I have received a copy of Nemaha County Community Health Services' NOTICE OF PRIVACY PRACTICES with the effective date of September 25, 2013.

______________________________ ______________________

Signature of Patient or Parent/Guardian Date