Ridgecrest Regional Hospital

1081 N. China Lake Blvd.
Ridgecrest, CA 93555
(760)446-3551

Pediatric TB and Lead Risk Assessment Questionnaire

Name of Child: Date of Birth: Today's Date:

Risk Factors For Tuberculosis in Children:		**YES**	**NO**	**Don't Know**
1.	Was your child born in an area that is high-risked for Tuberculosis?			
2.	Has your child traveled to an area that is high risk for T for more than 1 Week? If yes, specify which country:			
3.	Has a family member or contact had Tuberculosis disease?			
4.	Has a family member had a positive TST or IGRA results?			
5.	Has your child spent time (more than 3 weeks) with anyone who has been in jail/prison, homeless, shelter, uses illegal drugs, or has HIV?			
6.	Does your child drink raw milk or eat unpasteurized cheese?			
7.	Does your child have a household member who was born in an area that is high risk for Tuberculosis?			
8.	Does your child have a household member who has traveled to an area that is high risk for Tuberculosis			

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

Risk Factors For Lead Poisoning in Children:		**YES**	**NO**	**Don't Know**
1.	Does your child play or reside in a house with peeling or chipping paint?			
2.	Does your child have meals cooked or food stored in pottery/dishes made outside of the U.S?			
3.	Does your child live with someone whose job/hobby involves exposure to lead? (I.e., painting, soldering, vehicle repair, automobile battery manufacturing/recycling)			
4.	Has your child ever been anemic and/or had any blood problems?			
5.	Has your child taken any medications from another country?			
6.	Does your child attend day care with anyone with the above risk factors?			

If any of the risk factors are present, your child should be tested for lead. For any questions or information regarding lead consult your local Lead Poisoning Prevention Program at (661)868-0360.

Signature of Person Completing Form:

Staying Healthy Assessment

12 – 17 Years

Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School:
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables at least 2 times per day?	Yes	No	Skip	
3	Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Do you drink more than 12 oz. (1 soda can) per day of juice drink, sports drink, energy drink, or sweetened coffee drink?	No	Yes	Skip	
5	Do you exercise or play sports most days of the week?	Yes	No	Skip	Physical Activity
6	Are you concerned about your weight?	No	Yes	Skip	
7	Do you watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
8	Does your home have a working smoke detector?	Yes	No	Skip	Safety
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
10	Do you always wear a seatbelt when riding in a car?	Yes	No	Skip	
11	Do you spend time in a home where a gun is kept?	No	Yes	Skip	
12	Do you spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
13	Do you always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
14	Have you ever witnessed abuse or violence?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?	No	Yes	Skip	
16	Have you ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, down, or hopeless?	No	Yes	Skip	Mental Health
19	Do you spend time with anyone who smokes?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
20	Do you smoke cigarettes or chew tobacco?	No	Yes	Skip	
21	Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, Methamphetamine (meth), ecstasy, etc.?	No	Yes	Skip	

22	Do you use medicines not prescribed for you?	No	Yes	Skip	
23	Do you drink alcohol once a week or more?	No	Yes	Skip	
24	If you drink alcohol, do you drink enough to get drunk or pass out?	No	Yes	Skip	
25	Do you have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?	No	Yes	Skip	
	Your answers about sex and family planning cannot be shared with anyone, including your parents, without your permission.				
27	Have you ever been forced or pressured to have sex?	No	Yes	Skip	Sexual Issues
28	Have you ever had sex (oral, vaginal, or anal)? *If no, skip to question 35.*	No	Yes	Skip	
29	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
30	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
31	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
32	The last time you had sex, did you use birth control?	Yes	No	Skip	
33	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
34	Did you or your partner use a condom the last time you had sex?	Yes	No	Skip	
35	Do you have any questions about your sexual orientation (who you are attracted to) or gender identity (how you feel as a boy, girl, or other gender)?	No	Yes	Skip	
36	Do you have any other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**
PCP's Signature:		Print Name:			Date:
SHA ANNUAL REVIEW					
PCP's Signature:		Print Name:			Date:
PCP's Signature:		Print Name:			Date:
PCP's Signature:		Print Name:			Date:
PCP's Signature:		Print Name:			Date:

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

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

	yes	no	don't know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
9. Does the child have a parent, brother, or sister with an immune system problem?	☐	☐	☐
10. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
11. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
13. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

immunization action coalition
IAC
immunize.org

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (6/20)

PHQ-9: Modified for Teens

Name _____

Clinician _____ Date _____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the ***past year*** have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

Have you ***ever,*** in your ***whole life,*** tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

For Office Use Only Score_____

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Ridgecrest Regional Hospital

Community Care Clinics

Southern Sierra Medical Clinic, Southern Sierra Surgical Center, Healthy Bone and Joint

Patient Name: _____ Today's Date: _____

Social Determinants of Health Assessment Tool

To help identify health-related social needs (e.g., food, housing, social isolation, insurance, interpersonal violence, emotional well-being, transportation) in your patients, use this assessment tool to create a social determinants action plan. *Connect your patients with local and state community-based organizations that support social needs by visiting the 211.org website.*

FOOD	**YES**	**NO**
1. Within the past 12 months, did you worry your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought not last and you didn't have money to get more?		
HOUSING/UTILITIES		
3. Do you have housing?		
4. Do you worry about losing your housing?		
5. Within the past 12 months, have you or your family members you live with been unable to get heat, electricity, water when it was really needed?		
TRANSPORTATION		
6. Within the past 12 months, has lack of transportation kept you from going to medical appointments, getting your medicines, non-medical meetings or appointments, work, or from getting things that you need (Food)?		
SAFETY		
7. Do you feel physically and emotionally safe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?		
9. Within the past 12 months, have you been disgraced or emotionally abused in other ways by your partner or ex-partner?		
HELP NOW		
10. Do you have needs that are urgent? For example: I don't have food for today, I don't have a place to sleep tonight, I don't have a ride home or to work, I am afraid I will get hurt if I go home today.		
Additional Information:		

RIDGECREST REGIONAL HOSPITAL

CLINICS

TREATMENT CONSENT, PAYMENT AGREEMENT, AND INSURANCE RELEASE AND ASSIGNMENT

THIS AGREEMENT APPLIES TO ALL PATIENTS RECEIVING SERVICES AT REGIONAL HOSPITAL CLINICS -- SOUTHERN SIERRA MEDICAL CLINIC, HEALTHY BONE AND JOINT CENTER, SOUTHERN SIERRA SPECIALTY CENTER, RIDGECREST RURAL HEALTH CLINIC, RIDGECREST URGENT CARE CENTER, TRONA RURAL HEALTH CLINIC, CHINA LAKE COMMUNITY HEALTH CLINIC, AND MOBILE HEALTH CLINIC.

Patient Name: _____ **Birth Date:**_____

1. I consent to the procedures and/or medical services that may be performed during this course of treatment or while I am an outpatient. These may include, but are not limited to, medical or surgical examination, treatment or procedures, including emergency treatment or services if necessary, laboratory tests and procedures, X-ray examinations, telehealth services, anesthesia, photography for medical treatment (using clinic owned camera) or other outpatient hospital and clinic services provided to me under the general and special instructions of my physician or surgeon. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment in this hospital or clinic.

2. I understand that I am under the care and supervision of my attending physician. The hospital or clinic and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital or clinic services provided to me under my physician's general and special instructions.

3. I understand that I am responsible for all charges incurred as a result of such treatment as well as those incurred in collecting for treatment charges. I realize that even though I may have insurance coverage, I am still responsible for payment. If legal action is instituted for payment of such treatment and/or services, I agree to pay reasonable attorney fees and all costs incurred herein.

4. I agree to promptly pay all hospital or clinic bills in accordance with the charges listed in the hospital's or clinic's charge description master and, if applicable, the hospital's or clinic's charity care and discount payment policies and state and federal law. I understand that I may review the hospital's or clinic's charge description master before (or after) I receive services from the hospital or clinic. I understand that physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, may bill separately for their services. If any account is referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.

5. I authorize the release of any medical information necessary to process my insurance claim.

6. I irrevocably assign and transfer to the hospital and clinics, all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital or clinic of all insurance and health plan benefits payable for outpatient services. I agree that the insurer or plan's payment to the hospital or clinic pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with, and take all steps reasonably requested by, this hospital or clinic to perfect, confirm, or validate this assignment.

7. I authorize the use of this signature on all of my insurance claims submitted for me by the hospital or clinics.

8. I have read or received the Ridgecrest Regional Hospital Summary Notice of Privacy Practices.

9. No one will be able to pick up prescriptions or contact our office regarding my medical attention unless authorized below.

I authorize _____ Relationship _____

HIPAA

10. I understand prior to delivery of healthcare via telehealth, Ridgecrest Regional Hospital shall inform the patient about the use of telehealth and I shall give my consent either verbally or written for the use of telehealth as an acceptable mode of delivering healthcare services. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audios, video or data communicating. I understand that telehealth also involves the communication of medical information both orally and visually to practitioners located in California or outside of California. I understand that if my treatment is for tele-psych my medical/mental information may be communicated both orally and visually to practitioners in California or outside of California. I understand that I have the right to withhold or withdraw consent at any time. I understand that mental health records shall not be released to me (patient) without written consent. Mental health records shall not be released to the patient or parent if patient is a minor. I agree if the physician agrees to release the records, then all information that may be deemed detrimental to the patients so that they may cause harm to themselves or someone else will be redacted from the records. If a provider disagrees to release records, Ridgecrest Regional Hospital will inform the patient in writing.

11. I have read or received the Ridgecrest Regional Hospital E-Prescription Program and hereby provide informed consent to be enrolled in this program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

12. We participate in an Immunization Registry with California Immunization Registry (CAIR), a statewide, confidential database of patient immunization information. The purpose of CAIR is to consolidate immunization information among health care professionals, assure adequate immunization levels, and avoid unnecessary immunizations. Only you, your doctor, or health care workers who can assist you have access to your immunization information. If you do not want your immunization or tuberculosis (TB) screening test records to be shared with other health care providers, agencies, or schools in the CAIR, fill out and submit "Decline or Start Sharing Information Request Form" to CAIR via fax (888-436-8320). The form is available at the CAIR website (http://cairweb.org/cair-formsl) , or you may contact the CAIR Help Desk (800-578-7889 or CAIRHelpDesk@cdhp.ca.gov), or your health care provider for assistance.

13. CONSENT TO MEDICARE AUTHORIZATION (Medicare Patients Only): I request that payment of authorized Medicare benefits be made on my behalf to my provider as listed on this letter for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay my claim. If other insurance is indicated on item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. I understand that I am responsible to pay for the deductible and coinsurance portions of the charges, and for non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Administrative Contractor.

14. I agree by providing you my contact information, I authorize you and your associates to contact me at those numbers. This applies to any landline or cell phone number(s) I have provided you. I understand you may contact me by sending text messages or emails, using any email address I provided. I may be contacted by a prerecorded/artificial voice message or an automatic dialing device. I understand providing my phone number(s) is not a condition of receiving services

15. I understand that cellphone audio or video recording of patient care activities is not allowed

THIS AUTHORIZATION SHALL REMAIN IN EFFECT FOR ONE (1) YEAR FROM THIS DATE UNLESS REVOKED IN WRITING

Signature of Patient/Guardian: _____ **Date:**_____

Print Name: _____

If other than Patient, Indicate Relationship: _____

Disclaimer: Please be advised that completing preliminary health and insurance information does not establish a physician-patient relationship with our providers. Ridgecrest Regional Hospital will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the provider will accept you as a patient.

TREATMENT CONSENT, PAYMENT AGREEMENT AND INSURANCE RELEASE