

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:
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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

9 – 11 Years

Child's Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date	Grade in School:
Person Completing Form	<input type="checkbox"/> Parent <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Guardian <input type="checkbox"/> Other (Specify)			School Attendance Regular? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

					Nutrition
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one cup (8 oz.) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
					Physical Activity
6	Does your child exercise or play sports most days of the week?	Yes	No	Skip	Physical Activity
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
					Safety
9	Does your home have a working smoke detector?	Yes	No	Skip	Safety
10	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
11	Do your child always use a seat belt in the back seat (or use a booster seat if under 4'9")?	Yes	No	Skip	
12	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
13	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
14	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
15	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	

16	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
17	Has your child been hit or has your child hit someone in the past year?	No	Yes	Skip	
18	Has your child ever been bullied, felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
19	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
20	Does your child often seem sad or depressed?	No	Yes	Skip	Mental Health
21	Does your child spend time with anyone who smokes?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Has your child ever smoked cigarettes or chewed tobacco?	No	Yes	Skip	
23	Are you concerned your child may be using drugs or sniffing substances, such as glue, to get high?	No	Yes	Skip	
24	Are you concerned that your child may be drinking alcohol, such as beer, wine, wine coolers, or liquor?	No	Yes	Skip	
25	Does your child have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Has your child started dating or “going out” with boyfriends or girlfriends?	No	Yes	Skip	Sexual Issues
27	Do you think your child might be sexually active?	No	Yes	Skip	
28	Do you have any other questions or concerns about your child’s health or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient Declined the SHA
<input type="checkbox"/> Physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Alcohol, Tobacco, Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sexual Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP’s Signature:		Print Name:			Date:
SHA ANNUAL REVIEW					
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If your child is a baby, have you ever been told he or she has had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have a parent, brother, or sister with an immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.



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)?		
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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.		
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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 _____



**TREATMENT CONSENT, PAYMENT AGREEMENT
AND INSURANCE RELEASE**

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