CAMPUS HEALTH SERVICES
Please remit completed form to:
Patient Accounts
Campus Health Services
James A. Taylor Building, CB#7470
Chapel Hill, NC 27599

CAMPUS HEALTH SERVICES APPLICATION FOR SERVICES

*Please print clearly and complete all fields

Applicant's Name____
Last First MI

Mailing Address____

____

PID____________________ Telephone # ______________________ Birthdate____/____/______

Department Name____________________________________ Appointment Effective Date____/____/______

☐ I have attached the required information on my medical history.

REQUEST FOR OPTIONAL SPOUSAL/DOMESTIC PARTNER COVERAGE

☐ I request enrollment in the Campus Health Services Pre-Paid Health Care Plan for my spouse and certify that I am legally married to or a partner of____

Applicant's Signature____Date_______________

APPLICATION FOR SPOUSAL/DOMESTIC PARTNER COVERAGE

Name____
Last First MI

Mailing Address ____

____

PID____________________ Telephone #.______________________ Birthdate______/____/______

In addition to the premium for the BlueCross BlueShield of North Carolina Student Blue plan the monthly 2017-2018 health fee of $42.00 is also required.

Applicant's Signature____Date_________

Revised 05-24-17

JAMES A. TAYLOR CAMPUS HEALTH SERVICES

The University of North Carolina at Chapel Hill ▪ CB# 7470 ▪ Chapel Hill, NC 27599-7470 Fax: 919-966-0616 Email: Immunizations@unc.edu

REPORT OF MEDICAL HISTORY ☐ *POSTDOC* ☐ *PRIVATE PATIENT* ☐ *SPOUSE*

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN NAME PERSONAL ID#(PID)

PERMANENT ADDRESS CITY STATE ZIP CODE COUNTRY AREA CODE/PHONE NUMBER

DATE OF BIRTH (mm/dd/yyyy)______________ GENDER ☐ M ☐ F ☐ T PREFERRED PRONOUN___________ MARITAL STATUS S ☐ M ☐

EMAIL____ CELL PHONE NUMBER: ____

Year Entering: ___________________ Semester Entering: ☐ Fall ☐ Spring ☐ Summer 1 ☐ Summer 2

Postdoctoral Program: ____

Previously enrolled at another University? ☐ No ☐ Yes If Yes, Dates of Enrollment_________________

If previously enrolled at UNC – Chapel Hill, Dates of Enrollment: _____________________________

International: ☐ No ☐ Yes - Country of Origin_______________________ Primary Language: __________________________________

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

FAMILY & PERSONAL HEALTH HISTORY

Has any person, related by blood, had any of the following?

	Yes	No	Unknown
High blood pressure			
Stroke			
Heart attack before age 55			
Blood or clotting disorder			

	Yes	No	Unknown
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Unknown
Cancer (type):			
Alcohol/drug problems			
Psychiatric illness			
Suicide			

HEIGHT __________ WEIGHT __________

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year
High blood pressure			
Chicken Pox			
Heart trouble			
Pain or pressure in chest			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Head or neck radiation treatments			
Tumor or cancer (specify)			
Malaria			
Thyroid trouble (specify)			
Diabetes			
Serious skin disease			
Mononucleosis			

	Yes	No	Year
Hay fever			
Allergy injection therapy			
Arthritis			
Concussion or traumatic brain injury			
Frequent or severe headache			
Dizziness or fainting spells			
ADD/ADHD			
Paralysis			
Disabling depression			
Excessive worry or anxiety			
Ulcer (duodenal or stomach)			
Intestinal trouble			
Pilonidal cyst			
Frequent vomiting			
Gall bladder trouble or gallstones			

	Yes	No	Year
Jaundice or hepatitis			
Ulcerative colitis, Crohn's disease			
Severe or recurrent abdominal pain			
Hernia			
Easy fatigability			
Anemia or Sickle Cell Anemia			
Eye trouble besides need glasses			
Bone, joint, or other deformity			
Knee problems			
Recurrent back pain Or back injury			
Neck injury			
Broken Bones			
Kidney stones			
Kidney/Bladder infection			
Epilepsy			

	Yes	No	Year
Protein or blood in urine			
Hearing loss			
Frequent Sinus Infections			
Severe menstrual cramps			
Sexually trans. Infections (STI)			
Irregular periods			
Blood transfusion			
Drug use			
Alcohol use			
Anorexia			
Bulimia			
Tobacco Use			
Regularly exercise			
Other (specify):			

Medicines, hormonal contraceptives, vitamins, minerals, and any herbal/natural product (prescription and non-prescription) used:

Name ____________________ Use __________ Dosage ________ Name ____________________ Use __________ Dosage ________

Name ____________________ Use __________ Dosage ________ Name ____________________ Use __________ Dosage ________

Name ____________________ Use __________ Dosage ________ Name ____________________ Use __________ Dosage ________

Name ____________________ Use __________ Dosage ________ Name ____________________ Use __________ Dosage ________

Name:_______________________________________ PID#:________________________________

Adverse Reactions to:	No	Yes	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

Other Health Issues:	No	Yes	Explanation
Do you have any conditions or disabilities that limit your physical activities?			
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any paired organs? (Please describe)			
Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)			

Please indicate if and when you have had the following experiences: (please check at right of each item and if yes, indicate year of first occurrence)

	No	Yes	Year
Received counseling for mental health concerns			
Taken a prescribed medication for mental health concerns			
Been hospitalized for mental health concerns			
Seriously considered attempting suicide			

	No	Yes	Year
Purposefully injured yourself without suicidal intent (e.g., cutting, hitting, burning, etc.)			
Received treatment for alcohol or drug use			
Someone has sexual contact with you without your consent			
Experienced harassing, controlling and/or abusive behavior from another person			

Please indicate if and how often you engaged in these behaviors in the past 30 days:

	N/A	Never	Rarely	Sometimes	Regularly	Always
Wear a seat belt when in a car						
Eat 5 or more servings of fruits and vegetables per day						
Use a condom or protective barrier during sexual activity						

Within the last 30 days, on how many days did you use:

	Never used	Have used, not in last 30 days	1-5 days	6-19 days	20+ days
Tobacco Use					
Alcohol (beer, wine, liquor)					
Marijuana (pot, weed, hashish, hash oil)					

Campus Health Services at the University of North Carolina at Chapel Hill
CB #7470 | (p) 919.966.2281 | (f) 919.966.0616 | campushealth.unc.edu

CAMPUS HEALTH SERVICES PATIENT AGREEMENT

Permission for Diagnostic and Treatment Procedures: I authorize Campus Health Services (CHS), their employees and consultants, to perform diagnostic and treatment procedures that, in their judgment, may be medically necessary. I agree that I will be involved and engaged in my care and treatment. If I require specialized and/or emergency care, I will be referred to the appropriate medical facility or professional. I understand that a person listed as my emergency contact will be notified if considered necessary by the professional staff of CHS.

Confidentiality: Medical and mental health information contained CHS health record is strictly confidential and may only be released to outside sources with written permission from the patient, by a court order, or when permitted by law. Confidentiality and privacy is protected in all CHS business relationships to prevent the exchange of any patient specific information without permission. In the instance where an outside medical provider orders lab tests or allergy injections for patients at CHS, the results or follow-up from those tests or visits will be relayed back to the ordering provider. In addition, if a CHS provider refers you to an outside provider; your records pertaining to that referral may also be released.

Notification: I authorize CHS to contact me via University e-mail to include, but not limited to, appointment reminders, pre-matriculation immunization requirements, insurance claim inquiries, etc. I am aware that I may opt-out of receiving e-mail correspondence by calling CHS at (919) 966-2283. Because conventional email is inherently unsecured and the confidentiality of sensitive medical information cannot be assured, it is advised for matters that are sensitive in nature to contact CHS directly by calling 919-966-2281 or by sending a secure message through the patient portal at https://healthyheels.unc.edu.

Financial Information and Authorization to Process Insurance Claims: All UNC students are required to have health insurance either through an individual policy or through their family policy. CHS will file insurance claims on behalf of patients. The filing of claims does not guarantee either full or partial payment by the insurance company. For more information about using insurance at Campus Health Services (including which insurance companies are In-Network and Out-of-Network at CHS), please visit: http://campushealth.unc.edu/charges-insurance/using-insurance-campus-health. Please remember that the CHS Pharmacy is In-Network with virtually all US health insurance plans.

I, the undersigned, have read and understood the above information and authorize the release of any medical or insurance information to my insurance company and/or their agents, including but not limited to any plan administrator, pharmacy benefits manager, underwriter, or sponsor, which is necessary to process claims for services rendered by CHS. I hereby authorize my insurance company to distribute the payment of my coverage directly to CHS. I understand that I am fully responsible for all charges regardless of my insurance benefits. I authorize CHS to place any unpaid charges on my student account at the Office of Student Accounts and University Receivables (SAUR). I understand the office of SAUR may place a registration hold on my account for any unpaid CHS charges. I understand I can't use Title IV federal financial aid to pay CHS charges unless I have signed permission with the Office of Scholarship and Student Aid. If I am a student at UNC-Chapel Hill, I understand that I am responsible for any charges incurred by my spouse or partner if treated at CHS. I authorize the use of this signature on all insurance submissions. I may elect to pay any bill in full in lieu of submitting a claim for insurance reimbursement.

I verify by my signature below that I have read and understood the above information and give my permission as stated above.

Signature of Patient: ____ Date: ____________________

Printed Name of Patient: ____ PID#: ____________________

Signature of Parent/Guardian (If patient is under age18:__________________________Date: ____________________

Campus Health Services at the University of North Carolina at Chapel Hill
CB #7470 | (p) 919.966.2281 | (f) 919.966.0616 | campushealth.unc.edu

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Campus Health Services (CHS) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of CHS. My "protected health information" means medical, billing and demographic information about me collected from me and created or received by CHS which relates to my past, present or future mental or physical condition. I understand that diagnosis or treatment of me by CHS may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Except as noted below, CHS is not required to agree to the restrictions that I may request. However, if CHS agrees to a restriction that I request, the restriction is binding on CHS. CHS is required, and will agree to restrict disclosure of PHI about me to my health insurer when the PHI is solely related to a health care item or service for which I have paid in full out of pocket.

I have the right to revoke this consent, in writing, at any time. The revocation will be effective upon receipt, except to the extent that CHS has taken action in reliance on this consent.

I understand I have a right to review CHS's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of protected health information about me that will occur in my treatment, payment of my bills or in the performance of health care operations of the CHS. The Notice of Privacy Practices for CHS is also provided in various locations including on the CHS website at campushealth.unc.edu. The Notice of Privacy Practices also describes my rights and the CHS's duties with respect to protected health information about me.

CHS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing the CHS's website, calling the CHS office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

______________________________ ______________________________
Name of Patient/PID # Signature of Patient

______________________________ ______________________________
Name of Personal Representative Signature of Personal Representative

____
Date

____
Description of Personal Representative's Authority

us to disclose PHI to these people so that they may carry out their duties.
Organ Donor Organizations: We are required to share PHI about you for purposes of tissue, eye or organ donation.
Contacts: We may contact you to provide appointment reminders, to discuss treatment alternatives or other health related benefits that may be of interest to you as a patient. Our Pharmacy may contact you to remind you to pick up your prescriptions.
Fundraising: We may use and/or disclose certain PHI about you for fundraising purposes. This may include disclosure to a foundation, or contacting you to raise money for the organization and its operations. All fundraising communications will give you a way to opt out of receiving such communications in the future.
Food and Drug Administration (FDA): We may share PHI about you with certain government agencies like the FDA so they can recall drugs or equipment.
Workers Compensation and Your Employer: In certain circumstances, we may disclose PHI about you to your employer and your employer's workers' compensation carrier regarding a work-related injury or illness.
Public Health Activities: We may disclose PHI about you to public health agencies who are charged with preventing or controlling disease, injury or disability or as required by law. We may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition. Disclosures include for example, lifetime reporting to the North Carolina Cancer Registry information about cancer patients that we treat and is required by law.
Correctional Institution: We may disclose PHI about you to a correctional institution having lawful custody of you.
Law Enforcement: We may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.
As Required by Law: We must disclose PHI about you when required by federal, state or local law.
Health Oversight: We may disclose PHI about you to a state or federal health oversight agency, for activities -it is authorized by law to carry out, such as investigations and inspections.
Abuse, Neglect or Domestic Violence: We must disclose PHI about you to government authorities that are authorized by law to receive reports of suspected abuse, neglect or domestic violence.
Legal Proceedings: We may disclose PHI about you in the course of any judicial or administrative proceeding and in response to a court order, subpoena, discovery request or other lawful process.
Required Uses and Disclosures: We must make disclosures of PHI when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the HIPAA Privacy Regulations.
To Avoid Harm: We may use and/or disclose PHI about you when necessary to prevent or lessen a serious threat to your health or safety, or to the health or safety of the public or another person.
For Specific Government Functions: In certain situations, we may disclose PHI of military personnel and veterans for national security activities or other purposes, as required by law.
Marketing: We will not, without your advance authorization, use and/or disclose PHI about you to engage in a marketing activity for which we receive financial compensation, nor will we sell your PHI.

Application of Other Laws: If a use and/or disclosure of PHI about you described above is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. For example, some North Carolina laws provide more protection, with some exceptions, for specific types of information, including: specific communicable diseases (e.g., HIV/AIDS, syphilis, TB), mental health, developmental disabilities, and substance abuse.

Special Provisions for Minors: Under North Carolina law, minors, with or without the consent of a parent or guardian, have the right to consent to services for the prevention, diagnosis and treatment of certain illnesses including: venereal disease and other diseases that must be reported to the State; pregnancy; abuse of controlled substances or alcohol; and tional disturbance. If you are a minor and you consent to one of these services, you have all the authority and rights included in this Notice relating to that service. In addition, the law permits certain minors to be treated as adults for all purposes. These minors have all rights and authority included in this Notice for all services.

Other Uses of Protected Health Information: Under any circumstances other than those listed above, we will obtain your written authorization before we use or disclose PHI about you. If you sign a written authorization allowing us to use or disclose PHI about you in a specific situation, you can later revoke your authorization by contacting our Medical/Health Information Management Department. You must revoke your authorization in writing. The revocation will not apply to PHI about you that has already been used or disclosed in reliance on your authorization. Upon receiving your written revocation, we will not use or disclose PHI about you, except for disclosures already in process.

Updated March 2016

Notice of Privacy Practices

thrive
campushealth.unc.edu

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.

This Notice is provided on behalf of Campus Health Services. Campus Health Services provides ambulatory primary medical care, mental health services and wellness programs along with selected specialty services including gynecology and orthopedics to the eligible members of the Campus Community.

Purpose of Notice: This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or healthcare operations and for other purposes permitted or required by law. This Notice will also describe your rights and certain obligations we have prior to using or disclosing your PHI. "Protected Health Information" or "PHI" is information about you or your minor child, including demographic data such as name, address, phone numbers, etc., that may identify you or your minor child and that relates to your or your minor child's past, present or future physical or mental health and related healthcare services.

We understand that PHI about you is personal and confidential, and we are committed to protecting its confidentiality. We create a record of the care and services you receive at Campus Health Services to enable us to provide such services and to comply with legal requirements. We are required by law to provide this Notice and to maintain the privacy of PHI. We must abide by the most current version of this Notice, and we reserve the right to change the privacy practices described in it, with such changes to be effective for all PHI that we maintain. This Notice, including any updates, may be viewed on our web site, at **campushealth.unc.edu**. Notices will be posted in prominent areas of our facilities. You may receive a current copy by sending a written request to The University of North Carolina at Chapel Hill, Campus Health Services, Attn: HIPAA Liaison, CB# 7470, Chapel Hill, NC 27599-7470.

This notice describes the practices of Campus Health Services healthcare professionals, employees, Students-in-training and others who work or provide healthcare services at our facility.

If you think we have violated your privacy rights, you want to complain to us about our privacy practices, or you have any questions regarding the privacy of PHI about you, you can contact the UNC Privacy Office, Attn: Chief Privacy Officer, CB #1150, 440 W. Franklin St., Chapel Hill, NC 27599 or call (919) 962-6332 or email **privacy@unc.edu**.

You may also send a written complaint to the United States Secretary of the Department of Health and Human Services. Contact information can be found at the website for the Office of Civil Rights at **www.hhs.gov/ocr**. If you file a complaint, we will not take any action against you or change our treatment of you in any way.

Your Privacy Rights: You have the following rights relating to your Protected Health Information and may:

• Request a paper copy of this Notice.

• Inspect and/or obtain a copy of PHI in records used to make decisions about you. You have a right to a copy of such records in their original electronic version, or if this is not possible, in another electronic form that is mutually agreeable to you and us. We may charge you related fees. Under certain circumstances, we may deny this request. In some situations, you have the right to have the denial of your request reviewed by a licensed healthcare professional from Campus Health Services who was not involved in the original denial decision.

• Request that an amendment be added to your record. We will ask you to put these requests in writing and provide a reason that supports your request. We are allowed to deny these requests in certain circumstances.

• Request in writing a restriction on certain uses and disclosures of your PHI. We are not required to abide by the requested restrictions in most circumstances, however, we must agree to your request to restrict disclosure of PHI about you to your health plan for payment purposes when the PHI pertains solely to a health care item or service for which you, or someone on your behalf, have paid in full out of pocket.

• Obtain a record ("accounting") of certain disclosures of PHI about you.

• Make a reasonable request to have confidential communications of PHI about you sent to you by alternative means or at alternative locations.

• Revoke your authorization for use or disclosure of PHI about you, except that such revocation will not affect uses or disclosures permitted or required by law without authorization or any use or disclosure that already has occurred prior to the revocation. A revocation of authorization must be in writing and signed by you.

• Receive notice of any breach of your unsecured PHI.

You may exercise any of the above rights by contacting Campus Health Services Health Information Management Department, Attn: HIPAA Liaison, CB# 7470, Chapel Hill, NC 27599-7470, (919) 966-6557

Our Responsibilities: We are required by law to protect the privacy of your PHI; abide by the terms of this Notice; make this Notice available to you; and notify you if we are unable to agree to a requested restriction or an alternative means of communicating. We will obtain your general consent for some uses and disclosures of PHI about you, for other uses and disclosures of PHI about you we will obtain your authorization; and, in some circumstances, we may use and/or disclose PHI about you without your authorization.

Uses & Disclosures: Unless otherwise stated below, the use or disclosure described is permitted by law to be made without your authorization.

Treatment: We need to use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, we need to use and disclose PHI about you, both inside and outside our system, when you need a prescription, lab work, an x-ray, or other health care services. In addition, we need to use and disclose PHI about you when referring you to another health care provider.

Payment: Generally, we need to use and disclose PHI about you to others to bill and collect payment for the treatment and services provided to you by us or by another provider. Before you receive scheduled services, we may need to share information about these services with your health plan(s). Sharing information allows us to ask for coverage under your plan or policy and for approval of payment before we provide the services.

Regular Healthcare Operations: We may use PHI about you to review the care you received, how you responded to it, and for other business purposes related to operating our clinic. "Healthcare operations" also may include activities such as training or evaluating staff or trainees within our organization.

Business Associates: There are some services we provide through outside individuals or companies that we call "Business Associates", including vendors, contracted health care providers, offsite storage facilities, and liability insurance carriers. In order to protect PHI about you, "Business Associates" are required by law to provide appropriate safeguards and procedures for privacy and security of the PHI entrusted to them under their contract with us.

Communication with Involved Individuals: We may share PHI with a family member, a close personal friend, or a person that you identify, if we determine they are involved in your care or in payment for your care, unless you tell us not to do so. We may only disclose prescriptions to you and certain others, including your parent or guardian, or a person to whom you give written authorization. We will use our professional judgment and experience with common practice to allow a person to pick up non-prescription medical supplies and other medical information for you.

Psychotherapy Notes: Most uses and disclosures of psychotherapy notes will only be made after obtaining your authorization.

Research: We may disclose 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 health information.

Coroners, Medical Examiners, Funeral Directors: The law allows

THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

DIVISION OF STUDENT AFFAIRS

CAMPUS HEALTH SERVICES
JAMES A. TAYLOR BUILDING
CAMPUS BOX 7470
CHAPEL HILL, NC 27599-7470

http://campushealth.unc.edu

June 08, 2017

To: Postdoctoral Fellows and Family Members who are eligible to use Campus Health Services:

The staff at Campus Health Services welcomes you to Carolina. We look forward to assisting you with any health and wellness needs while you are here on campus. To assist us in this endeavor, we ask that you complete the health history form and return it to us at the address above on the letterhead. Please mark this **Attn: Patient Accounts**.

It is also the policy of Campus Health Services that all incoming Postdoctoral Fellows and family members eligible for services at CHS be screened for tuberculosis (TB). Please complete the TB screening questionnaire enclosed in this packet and mail a copy to Campus Health Services along with your health history form. Alternatively, you can fax a copy to 919-966-0616. If you answer "yes" to any of the questions on the screening questionnaire, you need to EITHER be tested for a TB infection OR you may need to make an appointment to see a CHS provider to discuss your individual situation.

Acceptable TB screening tests include the PPD/TST (Tuberculin Skin Test) or a TB blood test (e.g. QFT-G or T-spot). This PPD/TST or TB blood test must have been done within the past 12 months before coming to UNC. If you have had a TB skin test or the blood test for TB within the last year, please send the result to Campus Health Services. Only tests that were performed in a United States facility will be accepted. Also, if a PPD/TST was done, the test result must be documented in millimeters of induration to be considered valid.

If you have ever had a positive TB screening test, you will be required to schedule an appointment with a medical provider and provide appropriate documentation. If you have had a positive TB skin or blood test in the past and it was done in the US, you do NOT need another TB skin or blood test. However, you will need to have documentation that you had a chest x-ray after the positive TB test or you will need another chest x-ray. Again, this chest x-ray must have been done in a US facility.

If you cannot provide the results of the TB screening test, do not have a current TB screening test (within the 12 months), or if your current test was not done in a United States facility, please call 919-966-2281 and choose option 2 to schedule an appointment to get the test done at Campus Health Services. If you have any questions about this policy, please call 919-966-6573 and ask to speak with a nurse.

Sincerely,

Ken Pittman

Ken Pittman MHA FACHE
Interim Executive Director for Campus Health Services

Student Name: _________________________DOB:_____________ PID #:______________

Tuberculosis (TB) Screening Questionnaire *Please complete and return to Campus Health Services along with the Health History & Immunization Form and Patient Agreement.*

Please answer the following questions:		
Have you ever had close contact with persons known or suspected to have active TB disease?	❑ Yes	❑ No
Were you born in one of the countries listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below)	❑ Yes	❑ No

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cabo Verde
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Serbia
Serbia and Montenegro
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of $\geq$ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/data/download/en/

Have you had frequent or prolonged visits (this usually means a cumulative time of one month) to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries, above)	❑ Yes	❑ No
Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?	❑ Yes	❑ No
Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?	❑ Yes	❑ No
Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol?	❑ Yes	❑ No

If the answer is YES to any of the above questions, CHS strongly recommends that you receive TB testing as soon as possible and forward that result to CHS. Or you can get a TB screening test at CHS once school starts.
If the answer to all of the above questions is NO, no further testing or further action is required, please submit this form to Campus Health Services along with the Health History & Immunization for and Patient Agreement.

February 2017