PARKVIEW
OCCUPATIONAL HEALTH

Registration and Consent Form

PATIENT INFORMATION - *Please Print:*

Patient's Name: Last:_____ First:_____ Middle:_____ ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Street Address:_____ City:_____ State:_____ ZIP:_____

Home Phone Number:_____ Birth Date:_____ Age:_____ Sex: ☐ Male ☐ Female

Company:_____ Department:_____ Occupation:_____

Temp Agency: ☐ Yes ☐ No If Yes, Agency Name:_____

Emergency Contact Name:_____ Phone:_____ Relationship to Patient: _____

CONSENT OF HEALTH CARE RELATED SERVICE:

I authorize medical services, as determined by the physician(s)/medical provider. I also consent to medical services in addition to or different from those now contemplated which the attending physician(s)/medical provider deems necessary or advisable.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I have been offered a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand I should read it carefully. I am aware the notice may be changed at any time. ☐ **Accept** ☐ **Decline**

RELEASE OF MEDICAL INFORMATION:

I authorize Parkview Occupational Health and physician(s)/medical provider involved with my care to release medical information necessary to precede and pay the clinic charges and/or professional fees to appropriate third parties or to entities authorized to conduct utilization reviews. In the case of workman's compensation claims, the question of confidentiality among the hospital, attending physician(s)/medical provider and patients is waived.

I authorize release of my medical examination report information to my employer and/or their agents for Commercial Driver Fitness Determination related to the DOT physical. **As a courtesy Parkview Occupational Health will fax a copy of your physical to the Indiana or Ohio BMV. It is your responsibility to follow-up with the BMV for confirmation.

☐ **Yes** ☐ **No**

ASSIGNMENT/AUTHORIZATION TO PAY INSURANCE BENEFITS:

I assign Parkview Occupational Health and attending physician(s)/medical providers(s) all clinic expenses benefits, which are due for medical services. I authorize benefits to be paid directly to Parkview Occupational Health and the attending physicians(s)/medical providers(s).

AGREEMENT TO PAY:

The undersigned agrees, whether he or she signs as agent to a patient, that in consideration of the services to be rendered to the patient, he or she is hereby individually obligated to pay the account of the clinic and the attending physician(s)/medical provider(s) for all charges for services rendered in full, if not covered by employer's workman's compensation. Should the account be referred to any attorney or agency for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts will accrue interest at the legal rate. If litigation results, the amount of the attorney's fees shall be set by the court and not by the jury.

PATIENT'S PERSONAL ITEMS:

I understand that Parkview Occupational Health is not responsible for lost or damaged personal items that I bring into the facility.

PARENTAL MEDICAL CONSENT FOR MINORS:

Name of Parent Responsible for Minor:_____ Relationship to Patient:_____

Home Phone Number: Work Phone Number:

Minor's Name:_____ Birth Date:_____ Address (if different):_____

The above information is true to the best of my knowledge. I authorize Parkview Occupational Health the right to render service to my minor (less than 18 years of age) any diagnostic tests or treatment that is deemed advisable, and is to be provided by any medical provider of Parkview Occupational Health or any outside physicians or facilities as needed. This authorization is given in advance of any specific diagnosis or treatment that may be required.

☐ **Patient** ☐ **Guardian Signature:**

Date: _____

Picture I.D. Verified: ☐ Yes – Information Reviewed by Clinician: **Date**: _____

PARKVIEW

Hepatitis B Vaccine Offer

All employees who have the potential or who "reasonably anticipate" exposure to patients' blood and body substances while performing duties of their job are offered the Hepatitis B vaccine, free of charge, at Parkview.

Hepatitis B vaccine is very safe and effective. It will not cause Hepatitis B infection. The vaccine is not developed from human blood products; rather, it is derived from yeast cells.

A series of three intramuscular injections are given into the deltoid (arm) muscle at 0, 1 and 6 months. Studies have shown that over 90% of healthy adults developed complete protection against Hepatitis B virus after the vaccine was given.

The most common side effects following administration of the vaccine are: soreness and redness at the injection site for approximately 48 hours, and a low grade fever. Complaints of feeling tired and joint pain are infrequent and, if present, usually last for only a few days. Side effects usually decrease with subsequent doses. Hepatitis B vaccine should not be administered to individuals with hypersensitivity to yeast or vaccine components. This vaccine would not be expected to be harmful to a developing fetus; **however**, its safety of use for a fetus has not yet been clearly demonstrated.

A statement from your personal doctor will be required if you wish to receive the vaccine and have a condition requiring medication, are pregnant or nursing, or have a problem with allergies. You should not receive the vaccine when you are currently sick.

Hepatitis B is a viral infection that is caused by Hepatitis B virus (HBV). In the United States, 12,000 to 18,000 health care workers are infected annually with HBV. Of these health care workers, 200 to 300 die each year, while others may become chronic carriers of Hepatitis B, or develop chronic active hepatitis, cirrhosis or liver cancer.

Parkview encourages any employee who has exposure to blood and body substances on the job, to protect themselves from Hepatitis B by receiving the vaccine.

Please check the appropriate area below:

- ❑ **HEPBACC (Hepatitis B Vaccine Accepted)**
  My job may include exposure to blood and body substances. I am interested in receiving the Hepatitis B vaccine. I will receive the first vaccine today. I understand I need to return to Parkview Occupational Health/Employee Health Services in 1 month and 6 months in order to complete the 3 dose series. I will set appointments for those dates today.

- ❑ **HEPBDEC (Hepatitis B Vaccine Declined)**
  I understand that due to my occupational exposure to blood and body substances, I may be at risk of acquiring Hepatitis B virus. I have been given the opportunity to be vaccinated with Hepatitis B vaccine at no charge to me when my employment at Parkview begins. I decline the Hepatitis B vaccination. I understand that, by declining this vaccine, I will be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or body substances and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

I have read the above information and understand its contents.

Employee Signature: _____ SS#: _____

Health Service Nurse: _____ Date:_____

PARKVIEW

Blood Borne Disease Precautions

Health Care Workers (HCW) are at greater risk of being exposed to the Hepatitis B Virus (HBV), the Human Immunodefi ciency Virus (HIV) and other infectious diseases in the work place. **It is mandatory at Parkview to follow Universal Blood and Body Substance Precautions.** By doing so, it provides a greater protection to employees who are or may be exposed to blood and body substances. These precautions include, but are not limited to the following:

1. Gloves must be worn with all blood and body substance contact. Gowns, masks and eye protection must be worn with expected direct contact to blood and body substances on clothing or any part of the body.

2. When responding to Code Blue situations, use a CPR mask when mouth-to-mouth resuscitation is needed, until the Code Blue Team arrives.

3. Do not recap needles manually. If recapping is needed, use recapping devices. Place all used disposable sharp objects in the closest "sharps" container. Use hemostats instead of hands to remove sharp objects from holders.

4. Wash hands immediately following exposure to blood or body substances, including after removing gloves.

5. Dispose of infectious waste separately, in a clearly labeled container, which Parkview provides.

6. If you have draining lesions (including draining or red eyes), dermatitis or rash, you may not work until being evaluated and released for work by Employee Health Services.

7. You are responsible for learning the location and proper use of protective equipment in your work area and using it whenever appropriate.

8. Any exposure to the eye from blood or body substance must be seen in the Emergency Department (ED), immediately, for proper cleansing and flushing of the eye.

9. All contaminated needle or sharps punctures and mucous membrane exposures should be cleansed immediately and seen in Employee Health Services or the ED if Employee Health Services is closed, as soon as possible, for proper follow up treatment (must be done prior to leaving work).

10. If an exposure or injury does occur, your supervisor should be notifed and an Incident Report filled out and brought with you to Employee Health Services or the ED if Employee Health Services is closed.

I have read the above information and understand its contents.

Employee Signature: _____ SS#: _____

Health Service Nurse: _____ Date: _____

PARKVIEW

The purpose of this agreement is to ensure that food employees notify the **Nutrition & Dining Services person** in charge of past, current, and future conditions described. The person in charge will take appropriate steps to preclude the transmission of foodborne illness. This agreement is a legal requirement of the Indiana State Department of Health.

Applicant Name (print): _____

Address: _____

Telephone (H):_____ (W): _____

TODAY

Are you suffering from any of the following?

1. Diarrhea ☐ Yes ☐ No
2. Fever ☐ Yes ☐ No
3. Vomiting ☐ Yes ☐ No
4. Jaundice ☐ Yes ☐ No
5. Sore Throat with Fever ☐ Yes ☐ No
6. Lesions on the hand, wrist or exposed body part such as infected cut or burn ☐ Yes ☐ No

PAST

Diagnosed as being ill with typhoid fever (Salmonella typhi), shiegellosis (Shigella spp.), Escherichia coli (0157:H7 infection), or hepatitis A virus? ☐ Yes ☐ No

If yes, what was the date of diagnosis? _____

HIGH-RISK CONDITIONS

1. Have you been exposed to or suspected of causing a confirmed outbreak or diagnosed as being ill with typhoid fever (Salmonella typhi), shiegellosis (Shigella spp.), Escherichia coli (0157:H7 infection), Norwalk Virus, Norwalk-like Virus or hepatitis A virus? ☐ Yes ☐ No
2. Do you live in the same household with a person diagnosed with typhoid fever (Salmonella typhi), shiegellosis (Shigella spp.), Escherichia coli (0157:H7 infection), Norwalk Virus, Norwalk-like Virus or hepatitis A virus? ☐ Yes ☐ No
3. Do you have a household member attending or working in a setting experiencing a confirmed outbreak of typhoid fever (Salmonella typhi), shiegellosis (Shigella spp.), Escherichia coli (0157:H7 infection), Norwalk Virus, Norwalk-like Virus or hepatitis A virus? ☐ Yes ☐ No

Do you have a family doctor? ☐ Yes ☐ No

If yes: Name: _____

Address: _____

Telephone:_____

Signature of Applicant:_____ **Date**: _____

A copy of this document will be provided to the Applicant after signature is completed.

PARKVIEW OCCUPATIONAL HEALTH

Preplacement Medical History

Patient Name: _____ Date of Birth: _____ Date: _____

Employer: _____ Position: _____

Please note: To comply with GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) OF 2008, please do not provide any genetic information OR family history of disease (such as family history of heart attack, diabetes, high blood pressure, etc.) when answering any question on the medical history.

Work History and Readiness

1. Do you have any temporary or permanent work activity restrictions and/or an impairment rating from a healthcare provider?
(For example: no lifting above a certain weight or being prohibited from certain actions, like kneeling or squatting)
☐ No ☐ Yes, please describe the specific restriction(s)

2. Have you ever been hurt on the job? ☐ No ☐ Yes, please provide details and if you still have any ongoing issues from the injury

3. To your knowledge do you have any physical or mental disease, disorder, defect, handicap, disability, deformity or abnormality, or any other condition (including alcohol use disorder or any drug use or dependency) which might affect your ability to **safely perform the essential tasks and functions of this job**? ☐ No ☐ Yes, please describe

Personal Health and Wellness History

1. Please list any current prescription and over the counter medications, vitamins, and supplements you take, including dosage (if known), frequency, and how long you have taken them. ☐ I don't take any medications, vitamins, or supplements

2. Do you feel a medication/vitamin/supplement you take (or its side effects) will affect your ability to safely do your job?
☐ No ☐ Yes, please describe

3. Do you have any allergy, sensitivity, or reaction to a medication/vitamin/supplement/foods/other substance? ☐ No ☐ Yes, please describe

4. Are you under the care of a provider for any current medical conditions? ☐ No ☐ Yes, please describe

5. Would you like to make and/or learn more about how to make any lifestyle change(s) to improve your health?
(Some examples could be: exercise more, lose weight, eat better, stop smoking, etc.) ☐ Not at this time ☐ Yes, please describe

The above medical history information is complete and true to the best of my knowledge. I understand that any misstatement of fact may be, depending on employer policy, grounds for disciplinary action up to and including termination. I further understand that any willful misrepresentation of any medical condition can serve to bar any future claim for workers' compensation benefits.

Patient Signature: _____ Date: _____

Provider Comments:
☐ Patient attests reviewed medical history is correct. No reported conditions or concerns preventing safe performance of essential job tasks and functions.

Provider Signature: _____ Date: _____