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 employee 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:

☐ **HEPBPREV (Hepatitis B Previously Immunized)**
I will provide a vaccination record from a physician of a completed or in process Hepatitis B series.

☐ **HEPBACC (Hepatitis B Vaccine Accepted)**
My job will 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 do not expect to be in contact with patient blood and body substances on my job. I will contact Parkview Occupational Health/Employee Health Services if my job does involve exposure to blood and body substances.

☐ **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.

HEALTHCARE

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE
Part A

To the employer: _____ Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination. However, certain responses, or patterns of response, may lead the reviewer to request further information, or a medical examination, in order to reach a conclusion regarding the employee's ability to safely use a respirator.

To the employee, Patient ID:_____Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the healthcare professional who will review it.

CAN YOU READ? ☐ YES ☐ NO

Part A. Section 1. (Mandatory)
Every employee who has been selected to use **any** type of respirator must provide the following information.

1. Today's Date: _____ 2. Your Name: _____
3. Your age (to nearest year):____ 4. Sex: ☐ Male ☐ Female
5. Your height: _____ ft. _____ in. 6. Your weight: _____ lbs.
7. Your job title: Job title not in list: _____
8. A phone number where you can be reached by the healthcare professional who reviews this questionnaire (include the Area Code): _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No
11. Check the type of respirator you will use (you can check more than one category):
    a. ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
    b. ☐ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator? ☐ Yes ☐ No

    If "yes" what type(s): _____

Part A. Section 2. (Mandatory)

Every employee who has been selected to use **any** type of respirator must answer questions 1 through 9 below.

	Yes	No
1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?	☐	☐
2. Have you ever had any of the following conditions?		
a. Seizures (fits):	☐	☐
b. Diabetes (sugar disease):	☐	☐
c. Allergic reactions that interfere with your breathing:	☐	☐
d. Claustrophobia (fear of closed-in places):	☐	☐
e. Trouble smelling odors:	☐	☐
3. Have you ever had any of the following pulmonary or lung problems?		
a. Asbestosis:	☐	☐
b. Asthma:	☐	☐
c. Chronic bronchitis:	☐	☐
d. Emphysema:	☐	☐
e. Pneumonia:	☐	☐
f. Tuberculosis:	☐	☐
g. Silicosis:	☐	☐
h. Pneumothorax (collapsed lung):	☐	☐
i. Lung cancer:	☐	☐
j. Broken ribs:	☐	☐
k. Any chest injuries or surgeries:	☐	☐
l. Any other lung problem that you've been told about:	☐	☐
4. Do you currently have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath:	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace or level ground:	☐	☐
d. Have to stop for breath when walking at your own pace on level ground:	☐	☐
e. Shortness of breath when washing or dressing yourself:	☐	☐
f. Shortness of breath that interferes with your job:	☐	☐
g. Coughing that produces phlegm (thick sputum):	☐	☐
h. Coughing that wakes you early in the morning:	☐	☐
i. Coughing that occurs mostly when you are lying down:	☐	☐
j. Coughing up blood in the last month:	☐	☐
k. Wheezing:	☐	☐
l. Wheezing that interferes with your job:	☐	☐
m. Chest pain when you breathe deeply:	☐	☐
n. Any other symptoms that you think may be related to lung problems:	☐	☐

Part A. Section 2. (Mandatory) (Continued)

	Yes	No
5. Have you ever had any of the following cardiovascular or heart problems?		
a. Heart attack:	☐	☐
b. Stroke:	☐	☐
c. Angina:	☐	☐
d. Heart failure:	☐	☐
e. Swelling in your legs or feet (not caused by walking):	☐	☐
f. Heart arrhythmia (heart beating irregularly):	☐	☐
g. High blood pressure:	☐	☐
h. Any other heart problem that you've been told about:	☐	☐
6. Have you ever had any of the following cardiovascular or heart problems?		
a. Frequent pain or tightness in your chest:	☐	☐
b. Pain or tightness in your chest during physical activity:	☐	☐
c. Pain or tightness in your chest that interferes with your job:	☐	☐
d. In the past two years, have you noticed your heart skipping or missing a beat:	☐	☐
e. Heartburn or indigestion that is not related to eating:	☐	☐
f. Any other symptoms that you think may be related to heart or circulation problems:	☐	☐
7. Do you currently take medication for any of the following problems?		
a. Breathing or lung problems:	☐	☐
b. Heart trouble:	☐	☐
c. Blood pressure:	☐	☐
d. Seizures (fits):	☐	☐
8. If you've used a respirator, have you ever had any of the following problems?		
a. Eye irritation:	☐	☐
b. Skin allergies or rashes:	☐	☐
c. Anxiety:	☐	☐
d. General weakness or fatigue:	☐	☐
e. Any other problem that interferes with your use of a respirator:	☐	☐
9. Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire?	☐	☐

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

		Yes	No
10	Have you ever lost vision in either eye (temporarily or permanently)?	☐	☐
11	Do you currently have any of the following vision problems?		
	a. Wear contact lenses:	☐	☐
	b. Wear glasses:	☐	☐
	c. Color blind:	☐	☐
	d. Any other eye or vision problem:	☐	☐
12.	Have you ever had an injury to your ears, including a broken ear drum?	☐	☐
13.	Do you currently have any of the following hearing problems?		
	a. Difficulty hearing:	☐	☐
	b. Wear a hearing aid:	☐	☐
	c. Any other hearing or ear problem:	☐	☐
14.	Have you ever had a back injury?	☐	☐
15.	Do you currently have any of the following musculoskeletal problems?		
	a. Weakness in any of your arms, hands, legs, or feet:	☐	☐
	b. Back pain:	☐	☐
	c. Difficulty fully moving your arms and legs:	☐	☐
	d. Pain or stiffness when you lean forward or backward at the waist:	☐	☐
	e. Difficulty fully moving your head up or down:	☐	☐
	f. Difficulty fully moving your head side to side:	☐	☐
	g. Difficulty bending at your knees:	☐	☐
	h. Difficulty squatting to the ground:	☐	☐
	i. Climbing a flight of stairs or a ladder carrying more than 25 lbs:	☐	☐
	j. Any other muscle or skeletal problem that interferes with using a respirator:	☐	☐

Examiner Comments:

PARKVIEW
OCCUPATIONAL HEALTH

Physical Exam Medical History

Last Name: _____ First Name: _____ Date of Birth: _____ Gender: ____

Street Address: _____ City: _____ State/Province: ____ Zip Code: _____

Phone: _____ Personal Physician: _____ Exam Date: _____

Employer: Job Title:

Past Medical History

Do you have or have your ever had:	Yes	No
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	○
2. Seizures, epilepsy	○	○
3. Eye problems *(except glasses or contacts)*	○	○
4. Ear and/or hearing problems	○	○
5. Heart disease, heart attack, bypass, or other heart problems	○	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	○
7. High blood pressure	○	○
8. High cholesterol	○	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	○
10. Lung disease *(e.g., asthma)*	○	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	○
12. Stomach, liver, or digestive problems	○	○
13. Diabetes or blood sugar problems	○	○
Insulin used	○	○
14. Anxiety, depression, nervousness, other mental health problems	○	○
15. Fainting or passing out	○	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	○
17. Unexplained weight loss	○	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	○
20. Neck or back problems	○	○
21. Bone, muscle, joint, or nerve problems	○	○
22. Blood clots or bleeding problems	○	○
23. Cancer	○	○
24. Chronic (long-term) infection or other chronic diseases	○	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	○
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	○	○
27. Have you ever spent a night in the hospital?	○	○
28. Have you ever had a broken bone?	○	○

Please comment on any yes answers from questions 1-28.

Other health condition(s) not described above: ○ **Yes** ◉ **No**

Have you ever had surgery? If "yes," please list and explain below. ○ **Yes** ○ **No**

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*?
If "yes," please describe below. ○ **Yes** ○ **No**

Do you have any medication/supplement allergies or sensitivities? If "yes," please list and explain below. ◯ **Yes** ◯ **No**

Do you have temporary or permanent work/activity restrictions from a healthcare provider? If "yes," please list and explain below. ◯ **Yes** ◯ **No**

Do you have any prior work related injuries? If "yes," please list and explain below. ◯ **Yes** ◯ **No**

Social/Lifestyle History:

Tobacco: ◯ No ◯ Cigarettes ◯ Cigars ◯ Chew ◯ Ecig/vape

Alcohol: ◯ No ◯ Yes; frequency of ____ drinks per: ◯ Day ◯ Week ◯ Month ◯ Year

Typically more than 6 drinks at one sitting: ◯ Yes ◯ No

Employment: ◯ Unemployed ◯ Employed - current occupation: _____

Previous experience in the position applied for: ◯ Yes ◯ No

Nutrition:

Meals per week from drive thru/restaurant/take out: ◯ 0 ◯ 1-4 ◯ 5-9 ◯ 10+

Servings of fruit and vegetables per day: ◯ 0 ◯ 1-2 ◯ 3-4 ◯ 5+

Cans of soda (regular or diet) per day: ◯ 0 ◯ 1-3 ◯ 4-6 ◯ 6+

Sleep: Usual hours per night: ◯ 0 ◯ 1-4 ◯ 5-6 ◯ 7-8 ◯ 8+ Sleep aids: ◯ No ◯ Yes _____

Stress: Stress level (1: low. 5: high): ____ Sources: ◯ Job ◯ Money ◯ Family ◯ Other

Coping strategies: _____

Preventive Care

Last family doctor checkup: ◯ <1year ◯ 1-3 years ◯ 4+ years

Last dental exam: ◯ <1year ◯ 1-3 years ◯ 4+ years

Last blood pressure check: ◯ <1year ◯ 1-3 years ◯ 4+ years

Last vision exam: ◯ <1year ◯ 1-3 years ◯ 4+ years

Last tetanus/diphtheria shot: ◯ <5years ◯ 5-10 years ◯ 10+ years

Last blood sugar check: ◯ <1year ◯ 1-3 years ◯ 4+ years

Activity:

Daily, you usually: ◯ Sit mostly ◯ Stand mostly ◯ Move around frequently

Days per week you exercise for 20+ minutes: ◯ 0 ◯ 1-3 ◯ 4+

Goals:

What lifestyle change(s) would you like to make to improve your health (if any)?

How important to you are lifestyle changes? (1: low. 5: high) ____

Patient Signature: Date: _____

Provider comments on history:

Reviewed by:

_____
Date