SALT LAKE COUNTY HEALTH DEPARTMENT

# Monkeypox Outbreak Encounter Form

Last Name _____ First Name _____ Middle Name/Initial _____ Date of Birth _____

Age _____ Sex _____ Race _____ Hispanic? Y N _____; Phone; may we text this #? Y N _____ Cell carrier

Mailing Address _____ City _____ State _____ ZIP _____

(If not self): Parent's Name _____ Parent's Date of Birth _____ Name of Insured Person _____ Insured's Date of Birth _____

1. Are you feeling well today? **Y N**
2. Allergies to foods or medications? **Y N**
   (If yes, type of allergy: _____)
3. Any problems with previous vaccines or fainting? **Y N**
4. Have you had blood products in the past 6–11 months? **Y N**
5. Any problems with your immune system? **Y N**
6. If you are female and over 9 years old, could you be pregnant? **Y N N/A**

**Additional for COVID-19 vaccination**

a. Are you currently in isolation or quarantine for COVID infection or exposure? **Y N**
   If yes, do you live in a group living facility of any kind? **Y N**
b. If you have had passive antibody therapy for COVID, has 90 days passed since completion?
   **Y N N/A**

## STOP! HEALTH DEPARTMENT USE ONLY BELOW

**Primary Insurance:** ☐ SelectHealth ☐ United Health Care ☐ Cigna ☐ EMI Health ☐ Aetna ☐ Medicare ☐ Medicaid ☐ PEHP

**X0504** Outreach Vaccination CPT Code for electronic tracking (included in ALL outreach EMR encounter entry)

| Administration Private Purchase | Administration VFC | Administration Grant/Special Project | Administration Medicare |
|---|---|---|---|
| 90471 – First Vaccine | 90471 SL First Vaccine | 90465 First Vaccine | G0008 Influenza Vaccine |
| 90472 – Additional Vaccines *U* _____ | 90472 SL Additional *U* _____ | 90466 Additional Vaccine *U* _____ | G0009 Pneumococcal Vaccine |
| 90473 – Flu Mist | 90473 SL Flu Mist | 90467 Admin/Grant – ***Oral/Intranasal Vaccine*** | |

**Outbreak CPT Codes**

| | | | | |
|---|---|---|---|---|
| X0490 Hepatitis B | X0482 Measles | X0492 Measles GAMMA | X0489 Men B | X0901 Monkeypox |
| X0485 Varicella | X0483 Mumps | X0487 Hepatitis A | X0488 Men MCV 4 (MenACWY) | |
| X0486 Pertussis | X0484 Rubella | X0491 Hepatitis A GAMMA | X0500 Flu OB | X0493 Flu (Grant) |

| CPT | ICD10 | Service | Lot # | Site | Dose | Route |
|---|---|---|---|---|---|---|
| 90662 | Z23 | Fluzone High Dose > 65 yrs | | | 0.5cc | IM |
| 90672 | Z23 | Flu Mist 2–49 yrs | | | 0.5cc | IN |
| 90682 | Z23 | Flublok > 18 yrs | | | 0.5cc | IM |
| 90686 | Z23 | Pres Free Quad Flu **(0.5cc)** | | | 0.5cc | IM |
| 90688 | Z23 | Multi Dose Quad Flu **(0.5cc)** | | | 0.5cc | IM |
| 90632 | Z23 | Hepatitis A Adult 19 + yrs | | | 1.0cc | IM |
| 90636 | Z23 | Twinrix Adult 18 + yrs | | | 1.0cc | IM |
| 90746 | Z23 | Hepatitis B Adult 20 + yrs | | | 1.0cc | IM |
| 90739 | Z23 | Heplisav-B > 18 yrs | | | 0.5cc | IM |
| 90651 | Z23 | 9vHPV Gardasil 9-45 yrs | | | 0.5cc | IM |
| 90707 | Z23 | MMR > 1 yr | | | 0.5cc | SQ |
| 90670 | Z23 | Prevnar 13 | | | 0.5cc | IM |
| 90715 | Z23 | Tdap > 7 yrs (Adacel) | | | 0.5cc | IM |
| 90716 | Z23 | Varicella > 1 yr | | | 0.5cc | SQ |
| 90732 | Z23 | Pneumo23 | | | 0.5cc | IM/SQ |
| 90734 | Z23 | Men MCV4 ≥ 2 mos | | | 0.5cc | IM |
| 90750 | Z23 | Shingrix Zoster | | | 0.5cc | IM |
| X0900 | B04 | JYNNEOS orthopoxvirus > 18y | FDP00002 / FDP00003 | | 0.5cc | SQ |
| | | | | | | |

**COVID-19 Service**

| | | | |
|---|---|---|---|
| Pfizer | CPT: 91300 | 0001A - Admin 1st dose<br>0002A - Admin 2nd dose<br>0003A - Admin 3rd dose<br>0004A - Admin Booster dose | Site<br>Lot # |
| Moderna | CPT: 91301 | 0011A - Admin 1st dose<br>0012A - Admin 2nd dose<br>0013A - Admin 3rd dose | Site<br>Lot # |
| Janssen J&J | CPT: 91303 | 0031A - Admin 1st dose | Site<br>Lot # |
| straZeneca | CPT: 91302 | 0021A - Admin 1st dose<br>0022A - Admin 2nd dose | Site<br>Lot # |
| | CPT: | - Admin 1st dose<br>- Admin 2nd dose | Site<br>Lot # |

***Provider Name***: _____ ***Date:*** _____

***Provider Signature***: _____

***Office Use Only*** **if applicable*

Payer Code: _____

Payer Name: _____

***Office Use Only***

**Client PID Number**: _____ **Date:** _____

**Registered: Employee Name** _____ **Close Out: Employee Signature** _____

# Conditions of Treatment

**Please read and initial each item below:**

_____ **Consent for Treatment**
I have received a copy and have read, or had explained to me, the information contained in the Vaccine Information Statement(s) about the vaccine(s) I have requested or have been recommended to me, their risks, and about the disease(s) that the vaccine(s) protect against. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated in the Vaccine Information Statement(s) stated above be given to me or to the person for whom I am authorized to make this request. I certify that these statements are true and accurate.

_____ **Insurance Coverage**
*Applies only if billing Medicaid, Medicare, and/or a Salt Lake County Health Department-contracted insurance*

I understand that my health insurance coverage may have certain restrictions and limitations. I agree to pay the full amount for any and all related charges, if they are not covered by my insurance. If I fail to pay for these services and charges within sixty (60) days of receiving notice that the charges are not covered for any reason, my account will be turned over to collections. In the event my account is turned over to collections, I agree to pay attorney fees and collection charges which may apply. I hereby request and authorize the Salt Lake County Health Department to submit claims to my Medicaid, Medicare and/or Health Department-contracted insurance.

_____ **Privacy Rights**
I have been provided and have had the opportunity to read Salt Lake County Health Department's Notice of Privacy Practices. Furthermore, any questions I had regarding the policy have been explained to me by the Health Department staff. In addition, I understand that I may request a copy of these practices in a reasonable alternative format. I agree that this information may be shared with health care providers, health care personnel, public health personnel and other health care professionals who have a legitimate need to access the immunization information to: verify immunization status; audits; conduct public health studies; and assist a patient or to protect the health of individuals closely associated with the patient. I understand that I have the right to revoke this authorization at any time by notifying the Salt Lake County Health Department in writing. This release of information will be effective until canceled in writing. I understand that once my data is shared with another individual or agency, it may lose the protections provided by the HIPAA Privacy Rule, and may be re-disclosed by that recipient.

**Indicate relationship to the person receiving services:**

☐ Self ☐ Parent ☐ Sibling (over 18) ☐ Grandparent

☐ Guardian ☐ Other: _____

**If under 18 years of age:**

I am a:

☐ Pregnant Minor ☐ Married Minor ☐ Homeless Teen

By signing, you indicate that you have read, understand, and agree to these terms; that you have received a copy of this document; and that you are the patient, guarantor, the patient's legal representative, or legally authorized to sign this agreement and accept these terms.

Patient Name (please print): _____

Your Name (please print): _____

Signature: _____ Date: _____