PATIENT NAME:	ASSESSMENT DATE:

Vaccines	Dates Given/ or Checked	Date Unknown/ or Outdated	Patient Signature
Flu vaccine		☐ **New Offered today** ☐ **Get IPA Authorization** ☐ **Refer for vaccination** ☐ **Provide Vaccination**	☐ **Accepted** ☐ **Declined** **Sign:**_____
Tdap		☐ **New Offered today** ☐ **Get IPA Authorization** ☐ **Refer for vaccination** ☐ **Provide Vaccination**	☐ **Accepted** ☐ **Declined** **Sign**_____
Pneumonia vaccine [if chronic illnesses] ☐ Pneumovax 23 ☐ Pnevnar 13		☐ **New Offered today** ☐ **Get IPA Authorization** ☐ **Refer for vaccination** ☐ **Provide Vaccination**	☐ **Accepted** ☐ **Declined** **Sign:**_____
Tuberculosis Screen ☐ TB-QFN-Gold ☐ CXR ☐ PPD (TST)		☐ **New Offered today** ☐ **Check: TB-QFN-Gold** ☐ **Refer to: CXR** ☐ **Administer PPD**	☐ **Accepted** ☐ **Declined** **Sign:**_____
Hepatitis - C Screen: [USPSTF recommends 1-time screening for HCV to all adults born between 1945-1965]	-	☐ **New Offered today**	☐ **Accepted** ☐ **Declined** **Sign:**_____

Reviewed by Nurse/ Provider_____ **Date:**_____

Name: _____ Medical Record #: _____

Age: _____ DOB: _____ Date: _____

Please answer the following questions by checking the appropriate box /
Conteste por favor a las preguntas siguientes y conteste con la respuesta apropiada:

1.	**Have you or anyone you see regularly been diagnosed or suspected of being sick with active TB disease?** ¿Ha sido usted o cualquier persona que usted ve regularmente diagnosticado o sospechado de ser enfermo con la enfermedad activa de la tuberculosis?	☐ Yes/Si ☐ No
2.	**Do you or have you had symptoms of TB, such as cough, chest congestion, fever, night sweats, and/or weight loss?** ¿Usted tiene o ha tenido síntomas de la tuberculosis, tales como tos, congestión del pecho, fiebre, sudor en las noches, y/o pérdida de peso?	☐ Yes/Si ☐ No
3.	**Do you have family members or frequent visitors who were born in high TB prevalent countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)?** ¿Usted tiene miembros de la familia o visitantes que nacieron en los países frecuentes de la alta tuberculosis (la mayoría de los países de Asia, de África, de América latina, partes de Europa Oriental)?	☐ Yes/Si ☐ No
4.	**Were you born in, or travel to high TB prevalence countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)?** ¿Usted nació dentro, o viajo a los países altos del predominio de la tuberculosis (la mayoría de lospaíses de Asia, de África, de América latina, partes de Europa Oriental)?	☐ Yes/Si ☐ No
5.	**Do you live in out of home placements (such as board & care or residential facilities)?** ¿Usted vive dentro de las colocaciones caseras (tales como casa de huéspedes o instalaciones residenciales)?	☐ Yes/Si ☐ No
6.	**Do you have HIV infection, or other immunosuppressive condition?** ¿Usted tiene la infección del VIH, u otra condición immunosuppresiva?	☐ Yes/Si ☐ No
7.	**Do you live with someone with HIV?** ¿Usted vive con alguien con el VIH?	☐ Yes/Si ☐ No
8.	**Do you live, or frequently visit, with persons who have been incarcerated in the last 5 years?** ¿Usted vivió, o visita con frecuencia, con personas que fueron encarcelados en los ultimos 5 años?	☐ Yes/Si ☐ No
9.	**Do you live among or been frequently around individuals who are homeless, migrant workers, users of street drugs, or residents in nursing homes?** ¿Usted vive entre o frecuenta los alrededores de individuos sin hogar, trabajadores emigrantes, usuarios de las drogas de la calle, o residentes en clínicas de reposo?	☐ Yes/Si ☐ No
10.	**Do you consume alcoholic beverages?** ¿Usted consume bebidas alcohólicas?	☐ Yes/Si ☐ No

TO BE COMPLETED BY THE MEDICAL STAFF / SER COMPLETADO POR EL PERSONAL MÉDICO:

Administer the Mantoux TB skin test to all adults who have any of the above risk factors (indicated by a Yes response) UNLESS:

1. The patient has a previously documented positive Mantoux TB skin test, or
2. The patient has had a TB skin test within the last 12 months, or
3. The patient has been vaccinated with BCG within the last 12 months.

Reason for TB skin test if other than periodic evaluation:
☐ work ☐ school ☐ TB contact ☐ prenatal ☐ other, specify: _____

Note: Only trained licensed personnel may read/interpret the skin test.

Nurse/Provider Signature: _____ Date: _____

Patient Name:	**DOB:**

Depression Screening PHQ-2

Over the last 2 weeks, how often have you been bothered by any of the following?	*If any YES response, Proceed to PHQ-9*	
1. Little interest or pleasure in doing things	☐ NO	☐ YES
2. Feeling down, depressed, or hopeless	☐ NO	☐ YES

☐ PHQ-2 Negative ☐ PHQ-2 Positive, proceed to PHQ-9

↓ ↓

Depression Screening PHQ-9

Over the last 2 week, how often have you been bothered by any of the following problems?	*Not At all*	*Several days*	*More than Half day*	*Nearly every day*
	0	1	2	3
1. Little Interest or pleasure in doing things.	☐	☐	☐	☐
2. Feeling down, Depressed, or Hopeless	☐	☐	☐	☐
3. Trouble Falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself - or that you are a failure or have let yourself or family down	☐	☐	☐	☐
7. Trouble Concentrating on things, such as reading the Newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have Noticed. Or have you been restless and moving around a lot	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
	0			
	TOTAL SCORE:			

10. If you checked off any problems, how difficult have this problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely difficult

INTERPRETATION : ☐ ***1-4 MIN*** ☐ ***5-9 MLD*** ☐ ***1-14 MOD*** ☐ ***15-19 MSD*** ☐ ***20-27 SD***

PLAN: Provide Community Resourced**,** Discussion of Treatment options by Physician

DOCUMENTED BY:

VIDA FAMILY PRACTICE, PC.

435 Arden Ave. Suite # 330 FAX: 877/548-0506 Tel. 818/548-8001
Glendale, CA. 91203

VIDA FAMILY PRACTICE, PC.

MEDICATION REFILLS

ENGLISH

To ensure that you receive the right medication at the right time, please contact your pharmacy one week prior to running out of your medications, so a refill may be requested from your provider by the pharmacy.

ARMENIAN

Որպեսզի ապահովել որ դուք ստանաք ձեր ճիշտ դեղորայքը ճիշտ ժամանակին, խնդրում ենք դիմել ձեր դեղատանը ձեր դեղորայքը վերչանալուց մեկ շաբաթ առաջ, վորպեզի ձեր բժիշկից պահանջեն ձեր վերանորոքված դեղատոմսերը.

RUSSIAN

Для обеспечения получения ваших правильных лекарств в нужное время, пожалуста свяжитесь с вашей аптекой за неделю до окончания ваших лекарств, чтобы они запросили обновления ваших медицинских рецертов у вашего врача.

PERSIAN

ب ه داروخانه خود ب رای اطم ی نان شدن از گرف تن ب ه موق ع داروهای خود،خواهشم ند ا ست ی ک ه ف ته ق بل
ده کرده ت ا داروخانه از پ ز شک ب خواهد ت ا داروهیی تان را ت جدی د کن مراجع

SPANISH

Para asegurar que usted reciba sus medicamentos correcto en el momento adecuado, por favor póngase en contacto con su farmacia una semana antes que terminan sus medicamentos, para que la farmacia solicita de su medico renover sus presctiones.

435 Arden Ave., Suite # 330 FAX: 877/548-0506 Tel. 818/548-8001
Glendale, CA. 91203