CONFIDENTIAL MEDICAL INFORMATION

Part II: Initial Health Surveillance Questionnaire

Information on page 3 and 4 should be completed by the employee only.
As an OSU employee, you are required to complete this questionnaire to help evaluate risks to your health related to animal exposure or infectious materials during your work. After reviewing your responses to this questionnaire, OSU Occupational Medicine staff may contact you to discuss further medical evaluation and/or diagnostic procedures. If your health information changes or you decline participation in this part of the program, please contact Occupational Medicine staff at:

Section A: Participant Information			
Name:			
Work address:			Date:
GT ID#:	DOB:		M ☐ F ☐
Work phone:	E-mail address:		
Participant status: (Check all that apply)	☐ Faculty ☐ Staff	☐ Grad Student ☐ Undergrad	☐ Other: _____

Section B: Medical History

Immunizations/Titers

Have you ever had any of the following immunizations?

Tetanus:	yes ☐ no ☐ Unsure ☐	**Date of most recent booster** (**REQUIRED**) _____	
Hepatitis B (series of 3):	yes ☐ no ☐ Unsure ☐	#1 _____ #2 _____ #3 _____	
Rabies (series of 3):	yes ☐ no ☐ Unsure ☐	#1 _____ #2 _____ #3 _____	
Rabies Titer:	yes ☐ no ☐ Unsure ☐	Date of most recent _____	

Personal Health History	**Yes**	**No**
1. Have you ever contracted an illness from animals or experienced an animal related injury?	☐	☐
If **yes**, explain:		
2. Have you been told by a physician that you have a chronic condition or a compromised immune system?	☐	☐
If **yes**, explain:		
3. Are you currently taking any medication that impairs your immune system (steroids, immunosuppressive drugs, or chemotherapy)?	☐	☐
If **yes**, please list:		
4. For women: Because some animal–borne infections can affect fetal outcome, are you pregnant, or planning to become pregnant in the next year? I choose not to answer ☐	☐	☐
5. For individuals working with sheep:		
a. Do you have a history of known valvular disease (heart murmurs) or congenital heart disease?	☐	☐
If **yes**, explain:		
Treatment (if applicable):		
b. Do you know if you have or ever had Q-fever?	☐	☐
If **yes,** date of diagnosis:		

ENVIRONMENTAL ALLERGIES/ASTHMA	Yes	No
1. Are you allergic to any animal(s)?	☐	☐
If **yes**, list animals:		
List all symptoms that occur when you are suffering from your allergies:		
Severity of Symptoms ☐ Mild ☐ Moderate ☐ Severe		
List treatment that you receive to relieve your allergies:		
2. Do you have any other known allergies? (e.g., latex, animal feed, or substances/chemicals used) If **yes, list:**	☐	☐
List symptoms that occur when you are suffering from your allergies:		
Severity of Symptoms: ☐ Mild ☐ Moderate ☐ Severe ☐ N/A		
List treatment that you receive to relieve your allergies:		
3. Do you have asthma?	☐	☐
If **yes**, list cause(s) of asthma (if you do not know, write unknown):		
List symptoms that occur when you are suffering from asthma:		
Severity of symptoms: ☐ Mild ☐ Moderate ☐ Severe		
List treatment that you receive to relieve symptoms:		
4. Do you have allergy symptoms or asthma specifically related to animals that you currently work with?	☐	☐
If **yes**, list symptoms:		
Severity of symptoms: ☐ Mild ☐ Moderate ☐ Severe ☐ N/A		
List treatment that you receive to relieve symptoms:		
5. Do you have any skin problems related to work?	☐	☐
If **yes**, describe:		
6. Do you wear a respirator/mask to perform any activities at work?	☐	☐
If **yes,** what kind?		
Were you fit tested by EH&S staff?	☐	☐
ADDITIONAL PERSONAL HEALTH CONCERNS		
Do you have any health or workplace concerns not covered by the questionnaire that you feel may affect your occupational health and would like to confidentially discuss with the Occupational Health Staff or your personal care physician?	☐	☐
If **yes**, please leave a phone # and best time to reach you:		

Section C: Signature of participant in program (Complete section A, B, C)

The above information is true and complete to the best of my knowledge and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and will not be released without my knowledge and written permission.

Signature of Participant _____ Date _____

EMPLOYER SERVICES-AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) HIPAA RELEASE

I authorize Concentra to use and disclose protected health information (PHI)from the record(s) of:

Patient's Name:_____ Birthdate: _____

Address:_____.

PURPOSE OF DISCLOSURE

□ **Occupational Injury** ☒ **Occupational Non-Injury** □ **Other**

CONFIRMATION OF WHO MAY RECEIVE COPIES OF YOUR RECORDS

Employer or Entity Name: GA Tech Environmental Safety

Address: 793 Marietta St NW STE 230 City: Atlanta St: GA Zip: 30318

Fax Number:_____ Confirmation Telephone Number: 404-894-4635

IN CONNECTION WITH THIS AUTHORIZATION:

- I am aware that copies of records for services rendered on_____(date of service) and subsequent related visits containing PHI which may include the results of tests or evaluations, including diagnosis, and medical history, transcription notes, and tests and evaluations performed that my employer, prospective employer or third party entity has ordered or requires.
- I give Concentra authorization to release to my employer, insurance company, and/or their representatives any medical information, including any psychotherapy notes,* psychiatric information, sexually transmitted diseases, alcohol and drug abuse and/or * HIV/AIDS status, which is obtained as part of the treatment for this work related injury/illness, or employment-related examination.
- I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand that I may revoke this authorization at any time, except to the extent that action has already been taken by Concentra, by providing a written request to the Center where my care was provided.
- I understand that Concentra may not deny treatment if I do not complete this authorization form, but may deny services when the services are only to create PHI for disclosure to a third party.
- I have a right to not sign this authorization or to limit the information I authorize to be disclosed to the minimum necessary, however, refusal to sign this authorization or to limit disclosure of my PHI may violate a condition of employment or prospective employment.
- I may revoke this authorization at any time, but I must do so by submitting a written notice to the Concentra center where I received services. However, if I am here for a work-related visit that is subject Workers' Compensation, under some state laws I am not allowed to revoke this authorization.

I have a right to receive a copy of this authorization.

_____ OR _____

Patient's Signature / Date: _____ Signature of Patient's Representative / Date: _____

_____ _____

Printed Name of Patient's Representative Explanation of your legal right to sign for Patient

For HIPAA questions related to this form, please contact the Privacy Office at 1-800-819-5571.

* I object to the release of psychiatric information, sexually transmitted diseases, alcohol and drug abuse, and/or HIV/AIDS status. I understand disclosure of this information will require me to sign a separate authorization. Patient Signature _____

Concentra®

Employer Services Patient Information

About You
Reason for Today's Visit

Injury care Physical exam DOT (CDL) certification Drug screen ☑ Other: Questionnaire Review

Social security number or Military DBN: _____ **Date of birth (MM/DD/YYYY):** _____

Last name: _____ **First name:** _____ **Middle initial:** ____

Address: _____ **Apartment number:** ____ **City:** _____ **State:** ____ **ZIP:** ____

Home phone: _____ **Work phone:** _____ **Cell phone:** _____

☐ **Male** ☐ **Female** ☐ **Single** ☐ **Married**

Email address: _____ **Concentra may send a detailed email:** ☐ Yes ☐ No

For security of your records, all emails containing protected health information (PHI) are sent encrypted.

*** Consent to Receive Text Messages:** By providing your personal cell phone number to Concentra, you are agreeing to receive text messages from Concentra, its related companies, and/or vendors regarding medical services. Your consent to receive such communication is not a condition of the provision of medical services.

Signature: _____ **Date:** _____

About Your Employer
Employer Requesting Services

Company name: GA Tech Environmental Safety **Location/store number:** Environmental Safety

Address: 793 Marietta St NW **Suite number:** 230 **City:** Atlanta **State:** GA **ZIP:** 30318

Is your employment arranged through a temporary hire agency? ☐ Yes ☑ No

Name of agency: _____ **Agency phone:** _____

Notice of Privacy Practices

Your name and signature below indicates that you have been made aware of Concentra's Notice of Privacy Practices (NOPP) on the date indicated. You understand that the NOPP is posted in the center and a copy will be provided to you if you request it. If this is your first date of service with Concentra, please indicate this to the front desk receptionist and he/she will provide you a copy of the NOPP. If you have any questions regarding the information in Concentra's Notice of Privacy Practices, contact Concentra's Privacy Office at 800-819-5571 or privacyoffice@concentra.com.

Name: (please print) _____ **Date notice received:** _____

Signature: _____ **Date:** _____

Consent

(If you are ONLY here for a Department of Transportation drug screen or breath alcohol test, skip this section. For all other services, please complete.)

The information provided is correct to the best of my knowledge. I will not hold Concentra, its health provider, or its employees responsible for any errors or omissions that I may have made in completing the information on this form.

Signature: _____ **Date:** _____

I give permission to Concentra to perform the following services that the physicians and other non-physician providers and assistants may deem to be necessary: (a) medical, surgical, and diagnostic (e.g., including but not limited to x-rays, blood draws, and laboratory tests) processes, treatments, and procedures; (b) administration of injections, medications, and immunizations (with immunizations to occur after my receipt of any applicable vaccine information statements ("VIS" or "VISs"); and (c) completion of medically appropriate tests for communicable and other diseases; and (d) completion of a pelvic examination, if medically appropriate.

Signature: _____ **Date:** _____