

TRANSMISSION VERIFICATION REPORT

TIME : 09/05/2018 08:44
NAME : AU STUDENT HEALTH
FAX : 3342443396
TEL : 3342443281
SER.# : BROB1J254642

DATE, TIME	09/05 08:40
FAX NO./NAME	918772692565
DURATION	00:03:45
PAGE(S)	08
RESULT	OK
MODE	STANDARD



328 FRONT STREET SOUTH / LA CROSSE, WI 54601
Telephone No. 866.284.8788 Facsimile 608.783.7532

FAX TRANSMISSION

****All documents are to be faxed to LHI the same day of the appointment. Facility to keep originals.****

Please use this cover page to return all documents to LHI for the Service member listed below. Do not include documentation for any other Service members or individuals scheduled at your facility by LHI. A separate fax transmission is required for each individual Service member. You will not need to include your own clinic's fax cover sheet in addition to this page.

FAX TO:
RHRP USAR/ARNG
877.269.2565
OR
608.796.9179

Refer to your provider checklist(s) for a listing of documents to be returned to LHI for the individual and services listed below. Please update any information that may not be correct and/or current, and sign below.

Service Member: Donald Anthony Robinson

Facility: AUM Student Health

Appt. Date/Time: 9/5/2018 9:00 AM

Phone: 334-244-3281

Order Number: 31153460

Fax: 334-244-3396

Returned By:

31153460--01
D-0-R



This facsimile and any attachments are intended only for the use of the addressee and may contain information that is privileged and confidential. If you are not the intended recipient or an authorized representative of the intended recipient, do not review, disseminate, distribute or copy the facsimile or attachments. You are hereby notified that any dissemination of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by email at information@logisticshealth.com or by telephone at 866.284.8788 and destroy the facsimile and any attachments or return them to us at Logistics Health Inc., 328 Front Street South; La Crosse, Wisconsin 54601. Thank you for your cooperation.



MEDICAL RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE			
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION <i>(Sign each entry)</i>				
IMMUNIZATION SF 600					
Vaccine/Dose/Route	Site	Manufacturer	Lot	Exp Date	VIS Form (Pub Date)
Hepatitis B 1.0 mL / IM		CSK	FT42N	2/3/21	☒ (07/20/16)

31153460-SF600HEPBICV3-01
D-159410332-RAdministered By: lyk RNDate: 9/5/2018

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
STUDENT HEALTH CENTER			
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.

WARD NO.

MUST BE PRINTEDService Member Donald Anthony RobinsonSSN 0197 Date of Birth 1/1/1997Unit Name 0206 TC CO MED TRK DET1**CHRONOLOGICAL RECORD OF MEDICAL CARE**

Medical Record

STANDARD FORM 600 (REV. 6-97)Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1



Reserve Health Readiness Program
Pre-Immunization Screening Questionnaire

Service Member: Private One Donald Anthony Robinson

SSN: 0197

Date of Birth: 1/1/1997

Service member must answer the following questions by checking the appropriate box. Your careful responses will help us determine which vaccines may be safely given today. If a question is unclear, please ask the healthcare provider to explain it. When complete, sign your name and date in the "Form completed by" fields.

Yes No

- ☐ ☒ Are you experiencing an active illness with or without a fever present?
- ☐ ☒ Do you have cancer, leukemia, AIDS, or any other immune system problem?
- ☐ ☒ Have you ever experienced an adverse reaction after receiving an immunization?

If yes, list immunization and reaction you experienced:

- ☐ ☒ Do you take cortisone, prednisone, other steroids, anticancer drugs, or have you had radiation treatments?

(Corticosteroid therapy usually is not a contraindication to administering live-virus vaccine when it is short term (i.e., <2 weeks); a low to moderate dose; long-term, alternate-day treatment with short-acting preparations; maintenance physiologic doses (replacement therapy); or administered topically (skin or eyes) or by intra-articular, bursal, or tendon injection. Corticosteroids used in greater than physiologic doses reduce the immune response to vaccine.)

- ☐ ☒ In the past year have you received a blood transfusion or been given a medication called immune (gamma) globulin?
- ☐ ☒ Do you have a history of fainting with injections/blood draws?
- ☐ ☒ Do you have allergies to medication, food, or any vaccine?

Please list known allergies:

- ☐ ☒ Do you take prescription medication?

Please list:

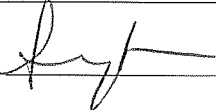
- ☐ ☒ Have you ever reacted positive to a TB Skin Test, received BCG, or been exposed to tuberculosis?
- ☐ ☒ Have you received a live virus (FluMist, MMR, Varicella, Yellow Fever) within the past four weeks?
- ☐ ☐ For women: Are you pregnant? Last menstrual period: _____

If Service member has indicated she is currently pregnant, I verify only injectable Flu vaccine can be administered ☐

All yes responses require RN comments:

Service Member Signature: Donald Robinson

Date: 08/01/2018

Provider Signature: 

Date: 8/5/18

Credentials