

**AUM NURSING CARE CENTER
IMMUNIZATION RECORD**

PATIENT NAME: Julie Freeman

BIRTHDATE: 4/27/57

ALLERGIES/MEDICAL ALERT: Demerol

IMMUNIZATION	DATE	SITE	DOSE	MFR	LOT #	COMMENTS	VIS/DATE	INITIALS
DPT								
DPT								
DPT								
DPaT								
DPaT								
DPaT								
DT								
DT								
DT								
Td BOOSTER								
Td BOOSTER								
MMR								
MMR								
MR								
MR								
HIB								
HIB								
HIB								
HEPATITS B								
HEPATITS B								
OTHER								
OTHER								
OTHER								

TUBERCULN TESTING PPD (MANTOUX) 0.1ml ID	DATE GIVEN	DATE READ	RESULTS	MFR	LOT #	COMMENTS	INITIALS
	4/1/11	4/4/11	0mm	SP	C3372AA	(L) fore arm	AM
	6/18/12	6/20/12	0mm	SD	C3991AA	(L) fore arm	AM
	8/28/19	8/30/19	0mm	SP	C5589AA	(L) fore arm	AM

INITIALS	SIGNATURE	INITIALS	SIGNATURE
AM	<i>[Signature]</i>		

AUBURN UNIVERSITY MONTGOMERY
 NURSING CARE CENTER
 IRMA B MOORE HALL RM 102
 P.O. BOX 244023
 MONTGOMERY, AL 36124-4023

**AUBURN UNIVERSITY MONTGOMERY
NURSING CARE CENTER**

P. O. Box 244023

Montgomery, Alabama 36124-4023

Phone: (334) 244-3281

Fax: (334) 244- 3396

This is to verify that a copy of the following records and/or lab results was given to

Julie C Freeman, R.N. on 10/1/07 :
Print Patient's Name Date

Description of record(s) copied: TB skin test, Hep B, Tet uTD
Hep booster

Julie C Freeman
Patient's Signature

10/1/07
Date

EARN student

American Heart
Association. 
Learn and Live.

Healthcare Provider

Julie Freeman

This card certifies that the above individual has successfully completed the national cognitive and skills evaluations in accordance with the curriculum of the American Heart Association for the BLS for Healthcare Providers (CPR & AED) Program.

6/22/2007

6/2009

Issue Date

Recommended Renewal Date

AHA
Region

Alabama

Community
Training Center

Empact Southeast Alabama

Training
Site

Instructor

Renee Coker

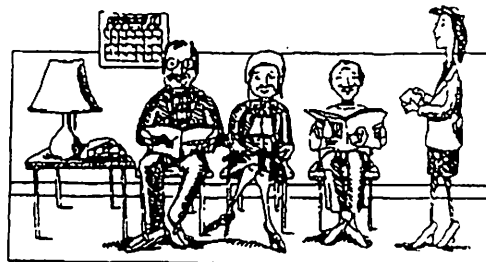
Holder's
Signature

©2000 American Heart Association Tampering with this card will alter its appearance. 70-2915

Patient name

Julie C. FreemanDate of birth: 64 / 27 / 57
(mo.) (day) (yr)

Screening Questionnaire for Adult Immunization



For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, or any vaccine? <u>Demerol</u>	☒	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☒	☐
5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?	☐	☒	☐
6. Do you have a seizure, brain, or nerve problem?	☐	☒	☐
7. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	☐	☒	☐
8. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
9. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

Form completed by: Julie C. FreemanDate: 06/20/07Form reviewed by: [Signature]Date: 6/20/07

Did you bring your immunization record card with you? yes ☐ no ☒

It is important for you to have a personal record of your vaccinations. If you don't have a record card, ask your healthcare provider to give you one! Bring this record with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

www.immunize.org/catg.d/p4065scr.pdf • Item # P4065 (9/06)

DOCTORS LABORATORY, INC.

2906 JULIA DRIVE
VALDOSTA, GEORGIA 31602
PHONE 800-342-7552



Medicare No. 65016769LA

P No. 28485-01

LA No. 11D0646134

PATIENT

FREEMAN, JULIE

PHYSICIAN

FUENTES

AUM NURSING CARE CENTER

7461 EAST DRIVE

MONTGOMERY, AL 36117

COLLECTED		RECEIVED	REPORT DATE	
04/18/2007		04/20/2007	04/23/2007	
2:00 PM		11:05 PM	6:00 AM	
ROOM #		ACCOUNT NUMBER	ORDER NUMBER	
		436099	I7334160	
AGE	SEX	FASTING	ROUTE	PAGE
49	F	UNKNOWN	9501	1
04/27/1957				

Pt Ph:

MRN:

PT ID#:

REQ#:

TEST NAME	WITHIN RANGE	OUTSIDE RANGE	REFERENCE RANGE	UNITS
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VARICELLA ZOSTER AB (IgG) 75.6 (H) < 15.0 EU/ML

Interpretation:

Reactive (Positive) for anti-VZV IgG; presumed immune to VZV

*** FINAL REPORT ***

EXCEPT WHERE NOTED: TEST PERFORMED AT DOCTORS LABORATORY, VALDOSTA, GA
DIRECTOR: JACKSON L. GATES, M.D.

ALLERGIES

Demerol

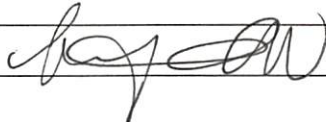
PHALCON LABEL

Name Julie Freeman

Date of Service 4/18/07

CHR # _____

PPD	DATE	RESULTS	PPD	DATE	RESULTS	PPD	DATE	RESULTS
MANTOUX			MANTOUX			MANTOUX		

Vaccine	Date Admin.			Age at the Time	VIS Type & Date	Manufacturer & Lot Number	Administration:		Q	Professional Signature
	Mo	Day	Yr				Amt.	Site & Route		
MMRV							0.5cc	SQ LA RA		
MMR							0.5cc	SQ LA RA		
MMR							0.5cc	SQ LA RA		
Varicella							Vial	SQ LA RA		
Varicella						Lot U1703BA Tetanus and Diphtheria Toxoids Adsorbed For Adult Use, DECAVAC™ US Govt Lic #1277 Mfd by: Aventis Pasteur Inc. Swiftwater PA 18370 USA CPT® Code: 90718	0.5 mL			
Tdap Td	4	18	07		6/94		0.5ccIM	LA RA		
Tdap Td							0.5ccIM	LA RA		
Tdap Td							0.5ccIM	LA RA		
Meningococcal Conjugate (MCV4, MPSV-4)							0.5ccIM	LA RA		
Pneumococcal 23-valent (PPV 23)							0.5ccIM	LA RA SQ		
Pneumococcal 23-valent (PPV 23)							0.5ccIM	LA RA SQ		
Hepatitis A							0.5cc	LA RA		
Hepatitis A							1cc IM	LT RT		
Hepatitis A							0.5cc	LA RA		
Hepatitis A							1cc IM	LT RT		
Influenza							0.25ccIM	LA RA		
Influenza							0.5ccIM	LT RT		
Influenza							0.25ccIM	LA RA		
Influenza							0.5ccIM	LT RT		
Rotavirus							PO			
Rotavirus							PO			
Rotavirus							PO			
TB skin test	5	3	10			03266AA Sanofi	① forearm			Read 5/5/10 Result AM @mm

IMMUNIZATION RECORD

PHALCON LABEL

Allergies:

Reactions:

Name _____

Date of Service _____

CHR # _____

Vaccine (Circle Vaccine Given)	Date Admin.			Age at the Time	VIS Type & Date	Manufacturer & Lot Number	Administration:			Q	Professional Signature
	Mo	Day	Yr				Amt.	Site	Route		
DTaP DT							0.5cc	IM	LA RA LT RT		
DTaP DT							0.5cc	IM	LA RA LT RT		
DTaP DT							0.5cc	IM	LA RA LT RT		
DTaP DT							0.5cc	IM	LA RA LT RT		
DTaP DT							0.5cc	IM	LA RA LT RT		
DTaP/Hib							0.5cc	IM	LA RA LT RT		
DTaP/HepB/IPV							0.5cc	IM	LA RA LT RT		
DTaP/HepB/IPV							0.5cc	IM	LA RA LT RT		
DTaP/HepB/IPV							0.5cc	IM	LA RA LT RT		
HepB							0.5cc 1cc	LA IM	RA LT RT		
HepB							0.5cc 1cc	LA IM	RA LT RT		
HepB							0.5cc 1cc	LA IM	RA LT RT		
HepB/Hib							0.5cc	IM	LA RA LT RT		
HepB/Hib							0.5cc	IM	LA RA LT RT		
HepB/Hib							0.5cc	IM	LA RA LT RT		
Hib							0.5cc	IM	LA RA LT RT		
Hib							0.5cc	IM	LA RA LT RT		
Hib							0.5cc	IM	LA RA LT RT		
Hib							0.5cc	IM	LA RA LT RT		
IPV							0.5cc	SQ	LA RA LT RT		
IPV							0.5cc	SQ	LA RA LT RT		
IPV							0.5cc	SQ	LA RA		
IPV							0.5cc	SQ	LA RA		
Pneumococcal 7-valent (PCV 7)							0.5cc	IM	LA RA LT RT		
Pneumococcal 7-valent (PCV 7)							0.5cc	IM	LA RA LT RT		
Pneumococcal 7-valent (PCV 7)							0.5cc	IM	LA RA LT RT		
Pneumococcal 7-valent (PCV 7)							0.5cc	IM	LA RA LT RT		

CHR 8

IMMUNIZATION RECORD

PHALCON LABEL

Allergies:

Reactions:

Name _____

Date of Service _____

CHR # _____

Vaccine (Circle Vaccine Given)	Date Admin.			Age at the Time	VIS Type & Date	Manufacturer & Lot Number	Administration:			Q	Professional Signature
	Mo	Day	Yr				Amt.	Site	Route		
DTaP DT							0.5ccIM	LA	RA		
DTaP DT							0.5ccIM	LA	RA		
DTaP DT							0.5ccIM	LA	RA		
DTaP DT							0.5ccIM	LA	RA		
DTaP DT							0.5ccIM	LA	RA		
DTaP/Hib							0.5ccIM	LA	RA		
DTaP/HepB/IPV							0.5ccIM	LA	RA		
DTaP/HepB/IPV							0.5ccIM	LA	RA		
DTaP/HepB/IPV							0.5ccIM	LA	RA		
HepB	6	20	07		Hep B #01		0.5cc 1cc	IM	LA LT	RA RT	Hyson
HepB							0.5cc 1cc	IM	LA LT	RA RT	
HepB							0.5cc 1cc	IM	LA LT	RA RT	
HepB/Hib							0.5ccIM	LA	RA		
HepB/Hib							0.5ccIM	LA	RA		
HepB/Hib							0.5ccIM	LA	RA		
Hib							0.5ccIM	LA	RA		
Hib							0.5ccIM	LA	RA		
Hib							0.5ccIM	LA	RA		
Hib							0.5ccIM	LA	RA		
IPV							0.5ccSQ	LA	RA		
IPV							0.5ccSQ	LA	RA		
IPV							0.5ccSQ	LA	RA		
IPV							0.5ccSQ	LA	RA		
Pneumococcal 7-valent (PCV 7)							0.5ccIM	LA	RA		
Pneumococcal 7-valent (PCV 7)							0.5ccIM	LA	RA		
Pneumococcal 7-valent (PCV 7)							0.5ccIM	LA	RA		
Pneumococcal 7-valent (PCV 7)							0.5ccIM	LA	RA		

CHR 8

Clinic Identification Stamp

PHALCON LABEL

Name _____

Date of Service _____

CHR # _____

PPD	DATE	RESULTS	PPD	DATE	RESULTS	PPD	DATE	RESULTS
MANTOUX			MANTOUX			MANTOUX		
PPD	DATE	RESULTS	PPD	DATE	RESULTS	PPD	DATE	RESULTS
MANTOUX			MANTOUX			MANTOUX		

Vaccine	Date Admin.			Age at the Time	VIS Type & Date	Manufacturer & Lot Number	Administration:	Q	Professional Signature
	Mo	Day	Yr				Amt. Site & Route		
MMRV							0.5cc SQ LA RA		
MMRV							0.5cc SQ LA RA		
MMR							0.5cc SQ LA RA		
MMR							0.5cc SQ LA RA		
Varicella							Vial SQ LA RA		
Varicella							Vial SQ LA RA		
Tdap Td							0.5ccIM LA RA		
Tdap Td							0.5ccIM LA RA		
Tdap Td							0.5ccIM LA RA		
Meningococcal Conjugate (MCV4, MPSV-4)							0.5ccIM LA RA		
Pneumococcal 23-valent (PPV 23)							0.5ccIM LA RA SQ		
Pneumococcal 23-valent (PPV 23)							0.5ccIM LA RA SQ		
Hepatitis A							0.5cc LA RA 1cc IM LT RT		
Hepatitis A							0.5cc LA RA 1cc IM LT RT		
Influenza							0.25ccIM LA RA 0.5ccIM LT RT		
Influenza							0.25ccIM LA RA 0.5ccIM LT RT		
Rotavirus							Oral/PO		
Rotavirus							Oral/PO		
Rotavirus							Oral/PO		

DOCTORS LABORATORY, INC.

2906 JULIA DRIVE
VALDOSTA, GEORGIA 31602
PHONE 800-342-7552



Medicare No. 65016769LA
LP No. 28485-01
CLIA No. 11D0646134

PATIENT FREEMAN, JULIE
PHYSICIAN FUENTES
AUM NURSING CARE CENTER
7461 EAST DRIVE
MONTGOMERY, AL 36117

COLLECTED 04/18/2007 2:00 PM		RECEIVED 04/18/2007 6:04 PM		REPORT DATE 04/19/2007 6:00 AM	
ROOM #		ACCOUNT NUMBER 436099		ORDER NUMBER K6082040	
AGE 49 04/27/1957	SEX F	FASTING UNKNOWN		ROUTE 9501	PAGE 1

Pt Ph: MRN: PT ID#: REQ#:

TEST NAME	WITHIN RANGE	OUTSIDE RANGE	REFERENCE RANGE	UNITS
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HEPATITIS B SURFACE ANTIBODY

Hep B Surface Ab

2.3

mIU/ml

IMMUNITY NOT INDICATED

Reference Ranges:

< 8.5 mIU/ml - Immunity not indicated
8.5 - 11.5 - Indeterminate
> 11.5 - Immunity Indicated

*** FINAL REPORT ***

EXCEPT WHERE NOTED: TEST PERFORMED AT DOCTORS LABORATORY, VALDOSTA, GA
DIRECTOR: JACKSON L. GATES, M.D.

DOCTORS LABORATORY, INC.

2906 JULIA DRIVE
VALDOSTA, GEORGIA 31602
PHONE 800-342-7552



Medicare No. 65016769LA
LP No. 28485-01
CLIA No. 11D0646134

PATIENT FREEMAN, JULIE
PHYSICIAN FUENTES
AUM NURSING CARE CENTER
7461 EAST DRIVE
MONTGOMERY, AL 36117

COLLECTED 04/20/2007 NO TIME		RECEIVED 04/20/2007 5:02 PM	REPORT DATE 04/24/2007 6:00 AM	
ROOM #		ACCOUNT NUMBER 436099	ORDER NUMBER 20722991	
AGE 49 04/27/1957	SEX F	FASTING UNKNOWN	ROUTE 9501	PAGE 1

Pt Ph: MRN: PT ID#: REQ#:

TEST NAME	WITHIN RANGE	OUTSIDE RANGE	REFERENCE RANGE	UNITS
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VERBAL REQUEST CONSENT
THE UNITED STATES CODE OF FEDERAL REGULATIONS REQUIRES A WRITTEN AND
SIGNED REQUEST BE FORWARDED TO A LABORATORY FOLLOWING A VERBAL ORDER
OF A LABORATORY TEST. PLEASE ASSIST US TO MEET THIS REQUIREMENT AND
TO COMPLETE OUR RECORDS.

DATE SIGNED: 4/24/07

PHYSICIAN: _____

AUTHORIZED SIGNATURE _____

YOUR SIGNATURE CONFIRMS YOUR ORDER OF THE FOLLOWING TEST(S).

PLEASE FAX THIS FORM TO: 229-249-5179

DOCTORS LABORATORY, INC.
ATTENTION: CLIENT SERVICES
P.O. BOX 4750
VALDOSTA, GA 31604

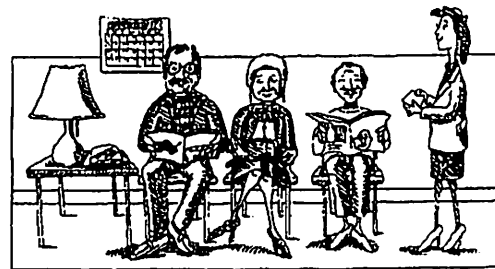
TEST(S) ADDED VARICELLA IGG 9619
ACCESSION ASSIGNED TO V.R.C K6082040
REQUESTED BY: AMY MORRIS

*** FINAL REPORT ***

EXCEPT WHERE NOTED: TEST PERFORMED AT DOCTORS LABORATORY, VALDOSTA, GA
DIRECTOR: JACKSON L. GATES, M.D.

Patient name: Julie C. FreemanDate of birth: 04 / 07 / 1957
(mo.) (day) (yr.)

Screening Questionnaire for Adult Immunization



For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, or any vaccine? <i>Demerol</i>	☒	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☒	☐
5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?	☐	☒	☐
6. Do you have a seizure, brain, or nerve problem?	☐	☒	☐
7. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	☐	☒	☐
8. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
9. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

Form completed by: Julie C. Freeman Date: 4/18/07

Form reviewed by: _____ Date: _____

Did you bring your immunization record card with you? yes ☐ no ☒

It is important for you to have a personal record of your vaccinations. If you don't have a record card, ask your healthcare provider to give you one! Bring this record with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

www.immunize.org/catg.d/p4065scr.pdf • Item# P4065 (9/06)

Nombre del paciente: _____

Fecha de nacimiento: ____/____/____
(mes) (día) (año)

Cuestionario para la vacunación de adultos



Para los pacientes: Las siguientes preguntas nos ayudarán a determinar cuáles vacunas debe recibir hoy. Si alguna pregunta no está clara, por favor pídale a su proveedor de salud que se la explique.

	Sí	No	No sabe
1. ¿Está usted enfermo en la actualidad?	☐	☐	☐
2. ¿Tiene alergias a medicamentos, alimentos, o alguna vacuna?	☐	☐	☐
3. ¿Ha tenido usted alguna reacción seria a las vacunas en algún momento?	☐	☐	☐
4. ¿Tiene usted cáncer, leucemia, SIDA, o cualquier otra enfermedad del sistema inmunológico?	☐	☐	☐
5. ¿Toma usted cortisona, prednisona, otros esteroides, drogas anticáncer, o ha estado expuesto a un tratamiento con rayos X?	☐	☐	☐
6. ¿En el curso del año pasado, ha recibido usted alguna transfusión de sangre, plasma, o una medicamento llamado gamaglobulina inmunológica?	☐	☐	☐
7. Para mujeres: ¿Es posible que usted esté embarazada o que quede embarazada en el próximo mes?	☐	☐	☐
8. ¿Ha recibido usted alguna vacuna durante las últimas cuatro semanas?	☐	☐	☐

Este formulario ha sido completado por: _____

Fecha: ____/____/____
(mes) (día) (año)

Este formulario ha sido repasado por: _____

Fecha: ____/____/____
(mes) (día) (año)

Trajo su tarjeta de vacunación? sí ☐ no ☐

Es importante que usted tenga una tarjeta personal con el registro de sus vacunas. Si usted no tiene una tarjeta, pídale a su proveedor de atención de la salud le dé una. Traiga esta tarjeta cada vez que busque atención médica. Asegúrese de que su proveedor atención de la salud le anote todas las vacunas en su tarjeta.

www.immunize.org/catg.d/p4065-01.pdf • Item# P4065-01 Spanish (4/04)