

AUM Student Health Services

Immunization Record

Patient Name: Yarlagadda Vyshnavi

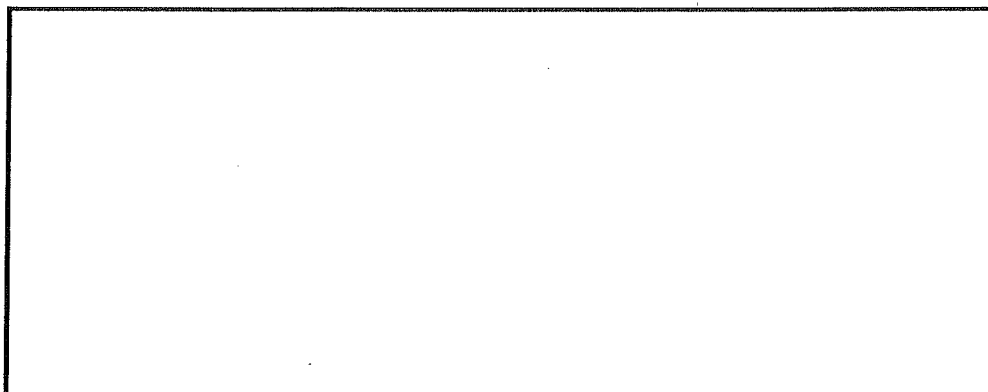
Birthdate: _____

Allergies/Medical Alert: _____

Immunization	Date	Site	Dose	MFR	Comments	Visit Date	Initials
Tdap							
Td Booster							
MMR							
HEP A							
HEP B							
Other							

	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	1/5/18	1/8/18	15 mm	SP	CS154AA	⑤ forearm	AM

Initials	Signature	Initials	Signature
AM	<i>[Signature]</i>		



STAMP ABOVE



East Montgomery Imaging Center
6880 Winton Blount Blvd
Montgomery, AL 36117
PHONE: 334-277-1210
FAX: 334-277-1781
FAX: 334-277-1454

for EMIC use only

PATIENT INFORMATION

Patient's Full Name Yarlagadda Vyshnavi DOB 11/10/95 Patient Phone: _____
Ordering Physician Carol Stewart Office Phone 244 8281 Office Fax 244 3396
Physician Signature/Date/Time [Signature] Cell Phone Number _____
Reason for Exam/DIAGNOSIS(Required) (+) TB skin test 1-8-18

SPECIAL INSTRUCTIONS

- ☐ STAT call # _____ ☐ STAT fax # _____ ☐ Send CD ☐ Send patient back to office
☐ EMIC to schedule ☐ EMIC to precertify exam ☐ Appt Date / Time _____
☐ Obtain i-Stat Creatinine prior to intravenous contrast administration (criteria on reverse side)

CT (Computerized Tomography)

- | | |
|---|--|
| ☐ Brain W/O Contrast | ☐ IAC's (Temporal Bone) |
| ☐ Brain W/O & W Contrast | ☐ Orbits |
| ☐ Sinus W/O | ☐ Soft Tissue Neck W |
| ☐ Chest W/O | ☐ Chest W |
| ☐ Abdomen W and Pelvis W (Routine) | |
| ☐ Abdomen/Pelvis W/O (Stone Hunt) | |
| ☐ Abdomen/Pelvis W/O & W (Hematuria Protocol) | |
| ☐ Abdomen W/O | ☐ Abdomen W/O & W |
| ☐ Pelvis W/O | ☐ Pelvis W |
| ☐ Cervical Spine ☐ W/O ☐ W | ☐ Bony Pelvis |
| ☐ Lumbar Spine ☐ W/O ☐ W | ☐ Other _____ |
| ☐ Thoracic Spine ☐ W/O ☐ W | ☐ 3-D Reconstruction |

CTA (CT Angiography)

- | | |
|--|---|
| ☐ CTA Brain (COW) | ☐ CTA Neck |
| ☐ CTA Abdominal Aorta | ☐ CTA Renals |
| ☐ CTA Pelvis | ☐ CTA Runoff-Bil Lwr Ext |
| ☐ CTA Chest (PE) | ☐ CTA Thoracic Aorta |

MRI (Magnetic Resonance Imaging)

- CONTRAST** W/O _____ W&W/O _____
- | | |
|---|---|
| ☐ Brain | ☐ MRCP (NPO 6hrs) |
| ☐ IAC's | ☐ Kidney |
| ☐ Pituitary | ☐ Liver |
| ☐ Orbits | ☐ Adrenals |
| ☐ Chest Wall | ☐ Hip ☐ R ☐ L ☐ Bilat |
| ☐ Brachial Plexus ☐ R ☐ L ☐ Bilat | ☐ Foot ☐ R ☐ L ☐ Bilat |
| ☐ Pelvis | ☐ Knee ☐ R ☐ L ☐ Bilat |
| ☐ Cervical Spine | ☐ Ankle ☐ R ☐ L ☐ Bilat |
| ☐ Lumbar Spine | ☐ Wrist ☐ R ☐ L ☐ Bilat |
| ☐ Thoracic Spine | ☐ Other _____ |
| ☐ Shoulder ☐ with arthrogram | ☐ R ☐ L ☐ Bilat |

MRA ANGIOGRAPHY

- | | |
|--|---|
| ☐ Intracranial - Circle of Willis | ☐ Renal Arteries |
| ☐ Carotids and Vertebrales | ☐ Other _____ |

FLUOROSCOPY

- | | |
|---|--|
| ☐ GI Series | ☐ BE |
| ☐ GI and Small Bowel | ☐ BE Air Contrast |
| ☐ Small Bowel | ☐ IVP |
| ☐ Esophagram | ☐ Other _____ |

NUCLEAR MEDICINE

- | | |
|--|---------------------------------------|
| ☐ Bone Scan Whole Body | ☐ Renal |
| ☐ Three Phase Bone Scan | ☐ MUGA |
| ☐ Thyroid (uptake and scan) | ☐ Liver/Spleen |
| ☐ Hepatobiliary Scan (HIDA) | ☐ Parathyroid |
| ☐ Gastric Emptying | ☐ Other _____ |

ULTRASOUND

- | | |
|--|--|
| ☐ Obstetrical | ☐ Pelvic |
| ☐ Pelvic/Transvaginal | ☐ Scrotum |
| ☐ Abdomen Complete | ☐ Abdomen (RUQ) |
| ☐ Thyroid | ☐ Hysterosonogram |
| ☐ Renal arteries | ☐ Renal / Kidney |
| ☐ Carotid | ☐ Aorta |
| ☐ Venous Doppler lower extremity | ☐ R ☐ L ☐ Bilat |
| ☐ Venous Doppler upper extremity | ☐ R ☐ L ☐ Bilat |
| ☐ Arterial Doppler lower extremity w/ segmental pressures | |
| ☐ Infant Spine | |
| ☐ Other _____ | |

ROUTINE X-RAYS

- | | |
|---|---|
| ☒ Chest | ☐ Cervical Spine |
| ☐ Abdomen Series | ☐ Thoracic Spine |
| ☐ Ribs ☐ LT ☐ RT | ☐ Lumbar Spine |
| ☐ KUB | ☐ Sinuses |
| ☐ Skull | ☐ Pelvis |
| ☐ Thoracolumbar (Scoliosis) | ☐ Other _____ |
| ☐ Extremity (specify) _____ | ☐ LT ☐ RT |

BONE DENSITY

- ☐ Bone DEXA Axial Skeleton

ADDITIONAL INFORMATION

Immunization (Vaccination) Form

To ensure the health and safety of our campus, immunizations against communicable diseases is extremely important. Vaccination against Measles, Mumps, Rubella (MMR) and Tetanus, Diphtheria and Pertussis is required of all students entering Auburn University Montgomery. This form must be completed and is the preferred document for proof of immunizations. Take this form to a doctor or clinic to be completed. Also, upon arrival to the campus, international students will be required to report to Student Health Services to receive a Tuberculosis Skin Test. The cost of this test is \$10.00. TB skin tests performed outside of the United States will not be accepted.

Name Vychnavi Yarlagadda Sree Student Number 500347191
Last First Middle
Local Address 15-45/1, Sri Srinivasacolony, V. Srinagar, Kanuru
Street City State Zip Code
Cell Phone Number _____ E-mail Address yarlagaddavychnavi@gmail.com Date of Birth (M/D/Y) 10/10/1995

REQUIRED IMMUNIZATIONS (Vaccinations)

Tetanus, Diphtheria, Pertussis Vaccine (preferred). Students without previous documentation of a TDaP vaccine should have one dose prior to entrance based on current guidelines. A DTaP will not be accepted.

Date of Tdap vaccine: 06 / 12 / 2017 (within the last 5 years).
D M Y

Measles, Mumps, Rubella (MMR) 2 separate vaccinations of the MMR, given at least 1 month apart is required.

Auburn Montgomery University requires that all students born after 1956 must have had 2 doses of a measles containing vaccine (MMR) prior to registration. One dose must have been after 1980. Lab antibody titers (IgG) for Measles, Mumps and Rubella are acceptable. Please attach documentation to the back of the form.

Date of First Dose 20 / 1 / 1997 Date of Second Dose 06 / 12 / 2017
D M Y D M Y

OPTIONAL IMMUNIZATIONS (These immunizations are not required by the university but are recommended by the American College Health Association.)

Hepatitis B: _____ / _____ / _____
1st 2nd 3rd

Varicella (Chickenpox) Vaccine: _____ / _____
1st 2nd

Meningococcal (meningitis) Vaccine: 06 / 12 / 2017 _____ / _____ / _____ (MCV4 preferred)
1st 2nd

I certify that the above dates and vaccinations are true.

Y. S. K. Me 06 / 12 / 2017
Signature of License Health Care professional Date License Number or Office Stamp

(Adopted 1/12, Revised 9/14)

GRANDAMAMA HOSPITAL
Reg. No: 43/18
Srinagar Colony, VIJAYAWADA-8.

Dr. Y. SAIKUMHORE
M.B.B.S., D.M., Physician
Regd. No: 47755