2025 SEATTLE/KING COUNTY CLINIC
PATIENT MEDICAL RECORD

PATIENT LABEL REQUIRED

PLACE PATIENT LABEL IN THIS BOX

Mark box for ROUTE if patient wants to receive service or if provider recommends/orders service. Advise patient that services are subject to availability. Routing does not guarantee service. Recommendations are only for the current day of service. Mark service as DONE once patient is seen.

ROUTE	DONE	PROVIDER ORDERED SERVICES	PG	QTY SVCS	PROVIDER OR TECH (PRINT)
		EKG	10	1	
		Lab: *See order form*	12		
		Ultrasound: *See order form*	10		
		X-Ray: *See order form*	11		

ROUTE	DONE	RETURN WITH RESULTS	
			Patient instructed to return after the following are completed:
			Provider Name (Print): _____ **Room #:** _____
			□ POC Lab □ Ultrasound □ X-Ray
			Provider Name (Print): _____ **Room #:** _____
			□ POC Lab □ Ultrasound □ X-Ray

ROUTE	DONE	PROVIDER RECOMMENDED	PROVIDER (PRINT)
		Healthcare Resources	

ROUTE	DONE	MEDICAL SERVICES — NO ORDER/REFERRAL REQ.	PG	QTY SVCS	PROVIDER OR TECH (PRINT)
		Acupuncture	5	1	
		Behavioral Health	5	1	
		Dermatology: □ Consult □ Skin Cancer Screen □ Cryo	6		
		Foot Care: □ General □ Podiatry	6		
		Immunizations: □ COVID-19 Booster □ Flu □ Hepatitis A/B □ MMR □ Shingles □ Tdap □ Other	3		
		Mammogram	7	1	
		Nutrition	7	1	
		Occupational (Hand, Wrist, Elbow) Therapy: □ General □ Splint □ Ortho □ Injections	8		
		Physical Therapy	8	1	
		Primary Care: □ General □ Naturopathic □ Pediatric	9	1	
		Primary Care: Women's + Trans/Nonbinary Health	9	1	

2025 SEATTLE/KING COUNTY CLINIC – IMMUNIZATIONS

Staple Immunizations Record behind page 1 of the Patient Medical Record

Patient Name (see label): _____ **Patient ID (see label): P**_____

SCREENING & CONSENT – *Please answer the questions listed below for the person receiving the vaccine(s).*	Yes	No
1. Are you sick today?		
2. Do you have allergies to medications, food (eggs, shellfish, etc.), a vaccine component, or latex?		
3. Have you ever had a serious reaction after receiving a vaccination (trouble breathing, fainting/ passing out, etc.)?		
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?		
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune-system problem?		
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or radiation treatments?		
7. Do you have a parent or sibling with an immune system problem?		
8. Have you had a seizure or brain or other nervous-system problem?		
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
10. For women: Are you pregnant or is there a chance you could become pregnant during the next month?		
11. Have you received any vaccinations in the past 4 weeks?		

Interpretation used? □ In person □ AMN Language Services

For the vaccine(s) I have initialed below, I have been given a copy of and have read or had explained to me the information in the Vaccine Information Statement(s) (VIS)). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) be given to me or to the person named below for whom I am authorized to make this request.

Initials:	**COVID-19 BOOSTER VACCINE ADMINISTRATION RECORD (For persons 18 years of age and older)**
	Lot number:
Dose 0.3mL or 0.5mL Site **(circle one)**: RA LA RT LT	**Date vaccine and VIS given:**

Initials:	**HEPATITIS A/B VACCINE ADMINISTRATION RECORD (For persons 18 years of age and older)**
Circle one: Twinrix or Havrix or Heplisav-B	**Lot number:**
Dose 0.5mL or 1.0mL Site **(circle one)**: RA LA RT LT	**Date vaccine and VIS given:**

Initials:	**INACTIVATED INFLUENZA VACCINE (IIV) ADMINISTRATION RECORD (For persons 18 years of age and older)**
Circle one: Fluzone or Fluzone HD *age 65+*	**Lot number:**
0.5mL dose given IM Site **(circle one)**: RA LA RT LT	**Date vaccine and VIS given:**

Initials:	**MEASLES, MUMPS, RUBELLA (MMR) VACCINE ADMINISTRATION RECORD (For persons 18 years of age and older)**
M-M-RII	**Lot number:**
0.5mL dose given IM Site **(circle one)**: RA LA RT LT	**Date vaccine and VIS given:**

Initials:	**RECOMBINANT SHINGLES VACCINE ADMINISTRATION RECORD (For persons 50 years of age and older)**
Shingrix	**Lot number:**
0.5mL dose given IM Site **(circle one)**: RA LA RT LT	**Date vaccine and VIS given:**

Initials:	**TETANUS, DIPHTHERIA, ACELLULAR PERTUSSIS (Tdap) ADMINISTRATION RECORD (For persons 18 years of age and older)**
Boostrix	**Lot number:**
0.5mL dose given IM Site **(circle one)**: RA LA RT LT	**Date vaccine and VIS given:**

Initials:	
	Lot number:
mL dose given IM Site **(circle one)**: RA LA RT LT	**Date vaccine and VIS given:**
Vaccinator Name / Title (print):	**Vaccinator Signature:**

Patient Name (print):	**Date of Birth:**

x _____ **Date:** _____

Signature of person receiving vaccine (or person authorized to make request—PARENT OR GUARDIAN)

PROVIDERS: Track service on page 1. Check DONE by service, list quantity, and print your name.

2025 SEATTLE/KING COUNTY CLINIC – MEDICAL TRIAGE & SERVICES

Staple this packet (pages 4 – 12) behind page 1 (plus 2 & 3 if immunizations received) of the Patient Medical Record

Patient Name (see label): _____ **Patient ID (see label): P**_____

Station Number: _____ **Triage Provider:** _____

Primary Medical Concern(s):

HEALTHCARE RESOURCES & VISIT RECOMMENDATIONS: Route patient to HCR on page 1. Complete form in patient's green folder as needed.

MEDICAL HISTORY

SOCIAL HISTORY

Living Situation:_____

Social Supports / Dependents: _____

SUBSTANCE USAGE

Intravenous Drugs: □ NO □ YES USAGE: _____

Non-intravenous & Prescription Drugs: □ NO □ YES USAGE: _____

ALCOHOL USAGE SCREENING (AuditC-2)	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2–4 times a month	2–3 times a week	4 or more times a week
2. How many standard drinks containing alcohol do you have on a typical day?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Subtotal					
See **Medical Triage Reference Packet** for scoring details.				**Total**	

BEHAVIORAL HEALTH SCREENING (PHQ-4)

Ask the patient the following questions, circle the number corresponding to the response.

Over the last two weeks, how often have you been bothered by any of the following problems?	Not at All	Several Days	More Than Half	Nearly Every Day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Little interest or pleasure in doing things.	0	1	2	3
4. Feeling down, depressed, or hopeless.	0	1	2	3
Subtotal				
See **Medical Triage Reference Packet** for scoring details.			**Total**	

PROVIDERS: Track service on page 1. Check DONE by service, list quantity, and print your name. Check ROUTE by service(s) that you ordered or recommended. If patient was told to come back with diagnostic results, fill out *Return with Results* section.

HEALTHCARE RESOURCES & VISIT RECOMMENDATIONS: Route patient to HCR on page 1. Complete form in patient's green folder as needed.

ACUPUNCTURE

HISTORY OF PRESENT ISSUE(s):

EXAMINATION:

ASSESSMENT/PLAN:

Due to limited capacity, patients should not be told/encouraged to come back for additional treatment on the same day or subsequent days.

PROVIDER NAME (Print): **DATE:**

BEHAVIORAL HEALTH

HISTORY OF PRESENT ISSUE(s):

EXAMINATION:

ASSESSMENT/PLAN:

PRESCRIPTION: Transcribe Written Rx, Quantity & Dosage

PROVIDER NAME (Print): **DATE:**

PROVIDERS: Track service on page 1. Check DONE by service, list quantity, and print your name. Check ROUTE by service(s) that you ordered or recommended. If patient was told to come back with diagnostic results, fill out *Return with Results* section.

HEALTHCARE RESOURCES & VISIT RECOMMENDATIONS: Route patient to HCR on page 1. Complete form in patient's green folder as needed.

DERMATOLOGY

LOCATION:

SERVICE TYPE(S) Check all that apply: □ Consult □ Skin Cancer Screen □ Cryo

EXAMINATION:

DIAGNOSTIC SERVICES: Complete order form.

• Lab (page 12) • Ultrasound (page 10) • X-Ray (page 11)

ASSESSMENT/PLAN:

PRESCRIPTION: Transcribe Written Rx, Quantity & Dosage

PROVIDER NAME (Print): **DATE:**

FOOT CARE

SERVICE TYPE(S) Check all that apply: □ General □ Podiatry

HISTORY OF PRESENT ISSUE(s):

EXAMINATION:

DIAGNOSTIC SERVICES: Complete order form.

• Lab (page 12) • Ultrasound (page 10) • X-Ray (page 11)

ASSESSMENT/PLAN:

PROVIDER NAME (Print): **DATE:**

PODIATRIST NAME (Print): **DATE:**

PROVIDERS: Track service on page 1. Check DONE by service, list quantity, and print your name. Check ROUTE by service(s) that you ordered or recommended. If patient was told to come back with diagnostic results, fill out *Return with Results* section.

HEALTHCARE RESOURCES & VISIT RECOMMENDATIONS: Route patient to HCR on page 1. Complete form in patient's green folder as needed.

MAMMOGRAPHY

REASON FOR EXAM: □ Routine Screening □ Symptomatic, describe:

FHCC TECH NAME (Print): **DATE:**

NUTRITION

HISTORY OF PRESENT ISSUE(s):

EXAMINATION:

ASSESSMENT/PLAN:

PROVIDER NAME (Print): **DATE:**

PROVIDERS: Track service on page 1. Check DONE by service, list quantity, and print your name. Check ROUTE by service(s) that you ordered or recommended. If patient was told to come back with diagnostic results, fill out *Return with Results* section.

HEALTHCARE RESOURCES & VISIT RECOMMENDATIONS: Route patient to HCR on page 1. Complete form in patient's green folder as needed.

OCCUPATIONAL (HAND, WRIST, ELBOW) THERAPY

HISTORY OF PRESENT ISSUE(s):

EXAMINATION:

DIAGNOSTIC SERVICES: Complete order form.

- Ultrasound (page 10)
- X-Ray (page 11)

ASSESSMENT/PLAN:

DX: □ Carpal Tunnel □ Trigger Finger □ Other:
TX: □ Injection □ Splint □ Other:

PROVIDER NAME (Print): **DATE:**

PROVIDER NAME (Print): **DATE:**

PHYSICAL THERAPY

HISTORY OF PRESENT ISSUE(s):

EXAMINATION:

DIAGNOSTIC SERVICES: Complete order form.

- Ultrasound (page 10)
- X-Ray (page 11)

ASSESSMENT/PLAN:

PROVIDER NAME (Print): **DATE:**

PROVIDERS: Track service on page 1. Check DONE by service, list quantity, and print your name. Check ROUTE by service(s) that you ordered or recommended. If patient was told to come back with diagnostic results, fill out *Return with Results* section.

HEALTHCARE RESOURCES & VISIT RECOMMENDATIONS: Route patient to HCR on page 1. Complete form in patient's green folder as needed.

PRIMARY CARE **LOCATION:**

SERVICE TYPE: □ General □ Naturopathic
□ Women's + Trans/Nonbinary Health □ Pediatric

VITAL SIGNS: BP _____ /_____ **HR** _____ **RR** _____ **Temp** _____ **LMP** _____ **/** _____ **/** _____ **GLUC** _____

HISTORY OF PRESENT ISSUE(s):

EXAMINATION:

DIAGNOSTIC SERVICES: Complete order form.

- EKG (page 10)
- Lab (page 12)
- Ultrasound (page 10)
- X-Ray (page 11)

ASSESSMENT:

PLAN:

PRESCRIPTION: Transcribe Written Rx, Quantity & Dosage

PROVIDER NAME (Print): **DATE:**

EKG (ROVING) **1) Provider completes order form below, calls for EKG unit. 2) Tech performs EKG, checks DONE by service on page 1, lists quantity, and prints name. 4) Provider reads EKG, consults cheat sheet or Medical Director as needed, documents results.**

PREVIOUS EKG ABNORMALITIES:

REASON FOR EXAM:

EKG RESULTS:

REVIEWING PROVIDER NAME (Print): **DATE:**

ULTRASOUND **1) Provider completes Order/Reason for Exam below and Return with Results section on page 1.**
2) Sonographer performs Ultrasound, checks DONE by service on page 1, lists total number of scanned areas completed, and prints name. 3) Radiologist reviews Ultrasound and completes Ultrasound Report below.

□ abdomen	□ gallbladder / pancreas	□ transvaginal pelvis
□ aorta	□ kidneys	□ testicular
□ breast: ____r ____l ____b	□ liver	□ thyroid
□ extremity nonvascular (r / l)	□ neck	□ other: _____

REASON FOR EXAM:

□ Patient should return to me (original provider) w/results.

□ I authorize an alternate provider to review and discuss the results with the patient. I confirm that the patient has been informed of this possibility.

ULTRASOUND REPORT:

SONOGRAPHER NAME (Print): **DATE:**

RADIOLOGIST NAME (Print): **DATE:**

X-RAY 1) Provider completes Order/Reason for Exam below and Return with Results section on page 1. 2) Tech performs X-Ray, checks DONE by service on page 1, lists total number of X-Rays completed, and prints name. 3) Radiologist reviews X-Ray and completes X-Ray Report below.

CRANIAL		**THORAX**		**ABDOMEN**	
☐	mandible	☐	chest 2-view	☐	abdomen / kub
☐	sinuses	**LOWER EXTREMITIES**		☐	abdomen 2-view
☐	waters view	☐	ankle 2-view (r / l)	☐	abdomen series
UPPER EXTREMITIES		☐	femur 2-view (r / l)	**SPINE**	
☐	ac joint series w/o weights (r / l)	☐	foot 2-view (r / l)	☐	c-spine 2-view
☐	ac joint series w/ weights (r / l)	☐	hips, bilateral	☐	c-spine 4-view
☐	ac joint series: zanca (r / l)	☐	hip (r / l)	☐	c-spine complete, 2-view, w/ obliques
☐	elbow 2-view (r / l)	☐	knee complete (r / l)	☐	t-spine 2-view
☐	finger(s) 2-view (r / l)	☐	knee sunrise (r / l)	☐	t-spine 4-view
☐	forearm 2-view (r / l)	☐	os calcis (heel) (r / l)	☐	l-spine 2-view
☐	hand 2-view (r / l)	☐	pelvis, ap	☐	l-spine 4-view
☐	humerus 2-view (r / l)	☐	tibia/fibula 2-view (r / l)	☐	l-spine complete, 2-view, w/ obliques
☐	shoulder 2-view (r / l)	☐	Other:		
☐	wrist 2-view (r / l)				
☐	specialty: ballcatchers' (r / l)				

REASON FOR EXAM:

☐ Patient should return to me (original provider) w/results.

☐ I authorize an alternate provider to review and discuss the results with the patient. I confirm that the patient has been informed of this possibility.

X-RAY REPORT:

TECH NAME (Print): **DATE:**

RADIOLOGIST NAME (Print): **DATE:**

LAB TESTS 1) Provider completes order below by writing initials in INITIAL box. Also completes Return with Results section on page 1 if wants to see patient about POC results. 2) Tech collects specimen, completes separate Labcorp requisition as needed. 3) Tech checks DONE by test(s) on order form below and completes POC Results as needed. 4) Tech also checks DONE by service on page 1, lists total number of labs completed, and prints name. 5) Except POC, results will be mailed to patient 2–3 weeks after Clinic.

Date of Collection:		**Time of Collection:**	
Collected by:		**Physician of Record:**	**Dr. Rick Arnold**

POINT-OF-CARE LAB RESULTS

URINALYSIS

Color		Specific Gravity		Nitrites	
Appearance		Blood		Leukocyte Esterase	
Glucose		pH			
Ketones		Protein			

RAPID STREP □ POS □ NEG **PREGNANCY** □ POS □ NEG

TECH NAME (Print): **DATE:**

ORDER FOR OFFSITE LAB TESTS

INITIAL	DONE	TEST NAME	SPECIMEN
		Complete Blood Count (CBC) with Differential	LAV
		Basic Metabolic Panel (BMP)	SST
		Hemoglobin A1c	LAV
		Hepatic Function Panel (HFP)	SST
		Lipid Panel	SST
		Urinalysis, Complete reflex to culture	Urine
		Thyroid Stimulating Hormone (TSH) reflex to FT4	SST
		Stool Occult Blood by FIT	FIT Kit
		Vitamin D (25-Hydroxy)	SST
		Syphilis Screen (TP) RPR	SST
		Chlamydia/GC - *collect in exam*	Aptima Tube
		Chlamydia/GC - Urine	Urine in Aptima
		Prostate Specific Antigen (PSA)	SST

ORDER FOR POINT-OF-CARE TESTS

INITIAL	DONE	TEST NAME	SPECIMEN
		Pregnancy Test	Urine
		Rapid Strep	Swab
		Urine Chemstrip	Urine

ORDER FOR OFFSITE LAB TESTS - OTHER

INITIAL	DONE	TEST NAME (Print):	SPECIMEN *(lab to enter)*

FOR LAB TRACKING ONLY

DONE	TEST NAME	SPECIMEN
	Cytology w/ reflex to HPV if ASCUS (See separate cytology requisition)	Thin Prep Vial
	Primary HPV reflex to Cytology (See separate cytology requisition)	Thin Prep Vial

REFERRING PROVIDER NAME (Print): **ROOM #:** **DATE:**

REFERRING PROVIDER NAME (Print): **ROOM #:** **DATE:**

REFERRING PROVIDER NAME (Print): **ROOM #:** **DATE:**

DIRECTOR AUTHORIZATION

□ FIN SVC: Service: Date: □ EMG REF: