

## 2026 SEATTLE/KING COUNTY CLINIC PATIENT MEDICAL RECORD

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.

**PATIENT LABEL  
REQUIRED**

**PLACE PATIENT  
LABEL IN THIS BOX**

ROUTE	DONE	PROVIDER ORDERED SERVICES	PG	QTY SVCS	Provider or Tech (Print)	
		EKG	10	1		
		Lab: <i>See order form</i>	12			
		Ultrasound: <i>See order form</i>	10			
		X-Ray: <i>See order form</i>	11			
ROUTE	DONE	RETURN WITH RESULTS	<i>Patient instructed to return after the following are completed:</i>			
			Provider Name (Print): _____		Room #: _____	
			<input type="checkbox"/> POC Lab	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> X-Ray	
			Provider Name (Print): _____		Room #: _____	
			<input type="checkbox"/> POC Lab	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> X-Ray	
ROUTE		PROVIDER RECOMMENDED				
Healthcare Resources (social work, health insurance assistance, community health center info)						

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

SAMPLE

## 2026 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.

<b>Initials:</b>	<b>COVID-19 BOOSTER VACCINE ADMINISTRATION RECORD (For persons 18 years of age and older)</b>		
		<b>Lot number:</b>	
Dose 0.3mL or 0.5mL	Site (circle one):	RA LA RT LT	<b>Date vaccine and VIS given:</b>
<b>Initials:</b>	<b>HEPATITIS A/B VACCINE ADMINISTRATION RECORD (For persons 18 years of age and older)</b>		
<b>Circle one:</b> Twinrix or Havrix or Heplisav-B		<b>Lot number:</b>	
Dose 0.5mL or 1.0mL	Site (circle one):	RA LA RT LT	<b>Date vaccine and VIS given:</b>
<b>Initials:</b>	<b>INACTIVATED INFLUENZA VACCINE (IIV) ADMINISTRATION RECORD (For persons 18 years of age and older)</b>		
<b>Circle one:</b> Fluzone or Fluzone HD <i>age 65+</i>		<b>Lot number:</b>	
0.5mL dose given IM	Site (circle one):	RA LA RT LT	<b>Date vaccine and VIS given:</b>
<b>Initials:</b>	<b>MEASLES, MUMPS, RUBELLA (MMR) VACCINE ADMINISTRATION RECORD (For persons 18 years of age and older)</b>		
<b>M-M-RII</b>		<b>Lot number:</b>	
0.5mL dose given IM	Site (circle one):	RA LA RT LT	<b>Date vaccine and VIS given:</b>
<b>Initials:</b>	<b>RECOMBINANT SHINGLES VACCINE ADMINISTRATION RECORD (For persons 50 years of age and older)</b>		
<b>Shingrix</b>		<b>Lot number:</b>	
0.5mL dose given IM	Site (circle one):	RA LA RT LT	<b>Date vaccine and VIS given:</b>
<b>Initials:</b>	<b>TETANUS, DIPHTHERIA, ACELLULAR PERTUSSIS (Tdap) ADMINISTRATION RECORD (For persons 18 years of age and older)</b>		
<b>Boostrix</b>		<b>Lot number:</b>	
0.5mL dose given IM	Site (circle one):	RA LA RT L	<b>Date vaccine and VIS given:</b>
<b>Initials:</b>			
		<b>Lot number:</b>	
mL dose given IM	Site (circle one):	RA LA RT LT	<b>Date vaccine and VIS given:</b>
<b>Vaccinator Name / Title (print):</b>			<b>Vaccinator Signature:</b>
<b>Patient Name (print):</b>			<b>Date of Birth:</b>
x _____			<b>Date:</b> _____
<i>Signature of person receiving vaccine (or person authorized to consent — PARENT OR GUARDIAN)</i>			
<b>PROVIDERS:</b> Track service on page 1. Check DONE by service, list quantity, and print your name.			

# 2026 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?	0 to 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
<b>Subtotal</b>					

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
<b>Subtotal</b>				

See **Medical Triage Reference Packet** for scoring details. **Total**

SAMPLE

**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  Biopsy

**HISTORY:**

**EXAMINATION:**

**DIAGNOSTIC SERVICES:** Complete order form.

- Biopsy (Avero Kit & Dir Auth)
- Lab (page 12)
- Ultrasound (page 10)
- X-Ray (page 11)

**ASSESSMENT/PLAN:**

**BIOPSY** Location:  
Differential:  
Anesthesia:  
 Lido 1% w/ epi  
 Lido 1% w/o epi  
 Punch:  4mm  6mm  
 Shave  
Hemostasis:  drysol  gelfoam

**CONSENT FOR BIOPSY:** I have been advised of the risks associated with a skin biopsy and I consent to this procedure.

x \_\_\_\_\_ **Date:** \_\_\_\_\_  
*Signature of person receiving biopsy (or person authorized to consent — PARENT OR GUARDIAN)*

**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 CONSULTATION**

**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  Pediatric  Women's + Trans/Nonbinary Health

**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.**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> abdomen                     | <input type="checkbox"/> gallbladder/pancreas | <input type="checkbox"/> transvaginal pelvis |
| <input type="checkbox"/> aorta                       | <input type="checkbox"/> kidneys              | <input type="checkbox"/> testicular          |
| <input type="checkbox"/> breast: ___ r ___ l ___ b   | <input type="checkbox"/> liver                | <input type="checkbox"/> thyroid             |
| <input type="checkbox"/> extremity nonvascular (r/l) | <input type="checkbox"/> neck                 | <input type="checkbox"/> 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		ribs		abdomen 2-view
	waters view	<b>LOWER EXTREMITIES</b>			abdomen series
UPPER EXTREMITIES			ankle 3-view (r/l)	SPINE	
	ac joint series w/o weights (r/l)		femur 2-view (r/l)		c-spine 2-view
	ac joint series w/ weights (r/l)		foot 3-view (r/l)		c-spine complete, 2-view, w/ flex-ex
	ac joint series: zanca (r/l)		hips, bilateral		c-spine complete, 2-view, w/ obliques
	elbow 3-view (r/l)		hip (r/l)		t-spine 2-view
	finger(s) 2-view (r/l)		knee complete (r/l)		t-spine 4-view
	forearm 2-view (r/l)		knee sunrise (r/l)		l-spine 2-view
	hand 3-view (r/l)		os calcis (heel) (r/l)		l-spine complete, 2-view, w/ flex-ex
	humerus 2-view (r/l)		pelvis, ap		l-spine complete, 2-view, w/ obliques
	shoulder 3-view (r/l)		tibia/fibula 2-view (r/l)		
	wrist 3-view (r/l)	Other:			
	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) Patient takes order to lab. 3) Quest staff confirms information on order is complete. 4) Quest staff enters order online, creates labels for specimen, and prints requisition. 4) Lab staff collects specimen. 3) Lab staff completes top of order form below, checks DONE by test(s), and completes POC Results as needed. 5) Lab staff checks DONE by service on page 1, lists total number of labs completed (including POC and cytology), and prints name. 6) 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			

<b>RAPID STREP</b> <input type="checkbox"/> POS <input type="checkbox"/> NEG	<b>PREGNANCY</b> <input type="checkbox"/> POS <input type="checkbox"/> NEG
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<b>TECH NAME (Print):</b>	<b>DATE:</b>
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<b>ORDER FOR OFFSITE LAB TESTS</b>	<b>ORDER FOR POINT-OF-CARE TESTS</b>
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INITIAL	DONE	TEST NAME	SPECIMEN	INITIAL	DONE	TEST NAME	SPECIMEN
		Complete Blood Count (CBC) with Differential	LAV			Pregnancy Test	Urine
		Basic Metabolic Panel (BMP)	SST			Rapid Strep	Swab
		Hemoglobin A1c	LAV			Urine Chemstrip	Urine

		Hepatic Function Panel (HFP)	SST	<b>ORDER FOR OFFSITE LAB TESTS - OTHER</b>			
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				INITIAL	DONE	TEST NAME	SPECIMEN <i>(lab to enter)</i>
		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	<b>FOR LAB TRACKING ONLY</b>			
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				DONE	TEST NAME	SPECIMEN
		Chlamydia/GC - <i>collect in exam</i>	Aptima Tube			
		Chlamydia/GC - Urine	Urine in Aptima		Cytology w/ reflex to HPV if ASCUS (See separate cytology requisition)	Thin Prep Vial
		Prostate Specific Antigen (PSA)	SST		Primary HPV reflex to Cytology (See separate cytology requisition)	Thin Prep Vial

<b>REFERRING PROVIDER NAME (Print):</b>	<b>ROOM #:</b>	<b>DATE:</b>
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<b>REFERRING PROVIDER NAME (Print):</b>	<b>ROOM #:</b>	<b>DATE:</b>
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<b>REFERRING PROVIDER NAME (Print):</b>	<b>ROOM #:</b>	<b>DATE:</b>
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**DIRECTOR AUTHORIZATION**

FIN SVC: \_\_\_\_\_ SERVICE: \_\_\_\_\_ DATE: \_\_\_\_\_

EMG REF: \_\_\_\_\_  BIOPSY: \_\_\_\_\_

# 2026 SEATTLE/KING COUNTY CLINIC – CYTOLOGY ORDER

Lab to staple Cytology Order behind page 12 of the Patient Medical Record

Patient Name (see label): \_\_\_\_\_ Patient ID (see label): P \_\_\_\_\_

**INSTRUCTIONS:** 1) Provider completes order including patient name and ID. 2) Patient takes order and specimen to lab. 3) Quest staff confirms information on order is complete. 4) Quest staff enters order online, creates label for specimen, and prints requisition. 5) Quest staff checks DONE on Medical Record page 12 by appropriate cytology test. 6) If additional lab tests weren't ordered, Quest staff checks DONE by service on Medical Record page 1, lists total number of labs, and prints name. 7) Quest staff staples Cytology Order page 13 to the back of patient's full Medical Record.

**SOURCE:**

- CERVIX       ANAL  
 VAGINA       CERVICO-VAGINAL

**COLLECTION:**

- CYTOBRUSH & SPATULA  
 CYTOBRUSH

- SPATULA  
 BROOM  
 DACRON SWAB (ANAL)

**LMP (LAST MENSTRUAL PERIOD)**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

- Post Menopausal  
 Postpartum

**IUD**       NO       YES

**PHYSICIAN OF RECORD:** RICK ARNOLD, MD

Date of Collection:

- Age 21-29: HPV DNA, PCR with Reflex to ThinPrep Cytology (Quest Test Code: 93296)  
 Age 30-65: HPV Rectal with Reflex to Genotyping (Quest Test Code: 92810)

**PHYSICIAN OF RECORD:** RICK ARNOLD, MD

**ROOM #:**

**PREVIOUS PAP/HPV HISTORY:**

SAMPLE