Record of Administered Services

Mercer County Health Department
305 NW 7th Street, Aledo, IL 61231

Phone: (309) 582-3759
Fax: (309) 582-3793

Patient's Age:	FULL LEGAL NAME - First:	Last Name:	Sex (Circle one): Male Female	Date of birth:

Mailing Address:	City:	Zip:	Patient phone:

FOR MINORS - Parent/Guardian Phone Number:

FOR MINORS - Parent/Guardian Name (please print):

Race (Circle One): *American Indian/Alaskan Native* *Asian/Asian-America* *African-American/Black* *Native/Indigenous Peoples* *Middle Eastern North African* *Native Hawaiian or other Pacific Islander* *White/European American* *Other race/s_____* *Unknown*

Ethnicity (Circle One): *Latina/Latino/Latinx/Hispanic* *Not Latina/Latino/Latinx/Hispanic* *Indigenous* *Unknown*

✓	IMMUNIZATIONS	DX	CPT	FEE
	DTAP	Z23	90700	
	Dtap/IPV (Kinrix)	Z23	90696	
	Dtap/IPV/Hep B (Pediarix)	Z23	90723	
	Hep A Adult	Z23	90632	
	Hep A Child	Z23	90633	
	Hep B Adult	Z23	90746	
	Hep B Child	Z23	90744	
	Hep A/Hep B	Z23	90636	
	HIB	Z23	90648	
	HPV	Z23	90651	
	IPV	Z23	90713	
	MMR	Z23	90707	
	MMRV	Z23	90710	
	Meningococcal	Z23	90734	
	Pneumovax 23	Z23	90732	
	Prevnar 13 (Child) (Adult)	Z23	90670	
	Rotavirus	Z23	90681	
	Shingles (Admin Only)	Z23	90736	
	TD	Z23	90714	
	Tdap	Z23	90715	
	DTAP/IVP/Hib (Pentacel)	Z23	90698	
	Varicella	Z23	90716	
	Prevnar 20	Z23	90677	
✓	**LAB SERVICES**	**DX**	**CPT**	**FEE**
	Hemoglobin A1c ---------- *Type 1 or Type 2*	Z00.00	83036	
	Hemoglobin (Finger stick)	Z00.129	85018	
	Lead Screening Child	Z00.129	83655	
	Pregnancy Testing-Negative	Z32.02	81025	
	Pregnancy Testing-Positive	Z32.01	81025	
	TB Skin Test-1 Step	Z11.1	86580	
	TB Skin Test-2 Step	Z11.1	86580	
	Capillary Blood Collection	Z00.129	36416	
	FIT Screening (Private Pay)	-0-	-0-	$20

✓	FLU SHOTS	DX	CPT	FEE
	Pediatrics 6 – 35 months	Z23	90685	
	Child	Z23	90686	
	High Dose 65+	Z23	90662	
	Adult Only	Z23	90686	
✓	**COVID-19 VACCINES**	**DX**	**CPT**	**FEE**
	PFIZER 12y-up: 1st dose	Z23-0121A	91312	n/a
	PFIZER 12y-up: add'l dose	Z23-0124A	91312	n/a
	PFIZER 5y-11y: 1st dose	Z23-0151A	91315	n/a
	PFIZER 5y-11y: add'l dose	Z23-0154A	91315	n/a
	MODERNA 12y-up: 1st dose	Z23-0011A	91301	n/a
	MODERNA 12y-up: 2nd dose	Z23-0012A	91301	n/a
	MODERNA 12y-up: 3rd dose	Z23-0013A	91301	n/a
	MODERNA 12y-up: add'l dose	Z23-0134A	91313	n/a
	MODERNA 6y-11y: 1st dose	Z230141A	91314	n/a
	MODERNA 6y-11y: 2nd dose	Z230142A	91314	n/a
	MODERNA 6y-11y: 3rd dose	Z23		n/a
	MODERNA 6y-11y: add'l dose	Z23-0144A	91314	n/a
	MODERNA 6m-5y: 1st dose	Z23-0111A	91311	n/a
	MODERNA 6m-5y: 2nd dose	Z23-0112A	91311	n/a
	MODERNA 6m-5y: 3rd dose	Z23-0113A	91311	n/a
	MODERNA 6m-5y: add'l dose	Z23-0164A	91316	n/a
✓	**NURSING SERVICES**	**DX**	**CPT**	**FEE**
	Developmental Testing	Z00.129	96110	
	Health Risk Pre-Natal: LMP _____	Z34.00	H1000	
	Health Risk Post-Natal (Modifier HD) Positive or Negative	Z13.89	96127	
	Preconception Risk Assess.	Z13.89	96160	
	Hearing Screening	Z01.10	92551	
	Injection: serum from client (i.e., B12)			
	Routine Infant 0–12 Mos. **NEW**	Z00.129	99381	
	Routine Child 1–4 Yrs. **NEW**	Z00.129	99382	
	Routine Infant 0-12 Mos. **EST**	Z00.129	99391	
	Routine Child 1-4 Yrs. **EST**	Z00.129	99392	
	Topical Fluoride Varnish	Z41.8	D1206	
	Vision Screening Child	Z01.00	99173	

FOR OFFICE USE ONLY, IF APPLICABLE	
Vaccine:	
Manufacturer:	
Lot number:	
Expiration:	
Site of injection:	L or R

FOR OFFICE USE ONLY, IF APPLICABLE	
Vaccine:	
Manufacturer:	
Lot number:	
Expiration:	
Site of injection:	L or R

FOR OFFICE USE ONLY, IF APPLICABLE	
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Manufacturer:	
Lot number:	
Expiration:	
Site of injection:	L or R

SIGNATURE OF PROVIDER AND TITLE	DATE OF SERVICE

(*If additional vaccines are given, please enter information on reverse side of this form.)

Payment Method (Check ALL that Apply)		
Bill To: ☐ Client ☐ Insurance ☐ Pay at Time of Service ☐ Medicare ☐ Medicaid ☐ VFC		
Payer information		
Name:	**Member DOB:**	**Relationship to Patient:**
Primary Insurance Plan Name:	**ID #:**	**Group #**
Secondary Insurance Plan Name:	**ID #:**	**Group #**

I authorize Mercer County Health Department to provide the services indicated on the reverse side of this form. Additionally, I authorize release of service-related information regarding the patient named on this form to third party payors and/or other health practitioners and to bill for service rendered to me or my minor child, if applicable. I request my payor to pay MCHD directly for services rendered to me, or my minor child. I understand that I am responsible for charges not covered by insurance.

If patient is under the age of 18: a custodial parent or legal guardian may consent on patient's behalf and sign this form; minors may not consent for vaccination unless emancipated by a court, pregnant, married, minor-parents, or a "minor seeking primary care" with verification of status in writing by a qualified adult under the IL Consent by Minors Act.

As the custodial parent or legal guardian, I authorize administration of services to the patient named on this form. If vaccinations are given at this visit, I know that side effects are normal, may or may not occur, and I will notify the patient's primary care provider of any adverse reactions. I further acknowledge receiving the "Vaccine Information Sheet" for any vaccine being administered.

Signature of patient if 18 years or older (or parent/legal guardian if under the age of 18) _____ **Date** _____

FOR OFFICE USE ONLY	
Total charges for services	$ _____
Co-Pay	$ _____
Additional amount paid	$ _____
BALANCE DUE	$ _____

☐ **Cash** ☐ **Credit/Debit** ☐ **Check #**_____

(*Additional vaccine information, if needed.)

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Manufacturer:	
Lot number:	
Expiration:	
Site of injection:	L or R

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Lot number:	
Expiration:	
Site of injection:	L or R

Payment Method (Check ALL that Apply)		
Bill To: ☐ Client ☐ Insurance ☐ Pay at Time of Service ☐ Medicare ☐ Medicaid ☐ VFC		
Payer information		
Name:	**Member DOB:**	**Relationship to Patient:**
Primary Insurance Plan Name:	**ID #:**	**Group #**
Secondary Insurance Plan Name:	**ID #:**	**Group #**

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Manufacturer:	
Lot number:	
Expiration:	
Site of injection:	L or R

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH ____/____/____
month day year

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) 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. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____