Maricopa County Department of Public Health

Sign In Sheet

Staff initials: _____

Patient initials: _____

PATIENT LABEL
(Last, First Name/ DOB/ eCW #, encounter date)

Date/Fecha: _____

Patient Identification Complete ☐

Translation Needed Yes ☐ No ☐

Name/Nombre:_____
LAST Name/*Apellido* **SUFFIX/*sufijo* (II, III, IV, Jr. Sr.)** **FIRST Name/*Primer nombre***

Address/ *Dirección*:_____ **APT./Suite/Bldng.: _____**

_____ _____ _____
City/*Ciudad* **Zip Code/*Código Postal*** **Phone Number/*Número de Teléfono*:**

Race/*Raza*: _____ **D.O.B./*Fecha de nacimiento***: _____ **Sex/*Sexo*: M / F / TMF / TFM**

Email Address: _____

HIV Status	Positive	Negative	Unknown	**Sexual Preference**	Males	Females	Both
Estatus de VIH	Positivo	Negativo	No Se mi estatus	**Preferencia Sexual**	Hombres	Mujeres	Ambos

Have you tested positive for Syphilis in the Past? Y / N *If yes, when and where*?_____

¿Alguna vez te diagnosticado con la Sifilis? *Si / No Si, contesto si, cuando y donde*?_____

Today you are being tested for Chlamydia, Gonorrhea, Syphilis and HIV
Hoy se le van a hacer pruebas para Chlamydia, Gonorrea, Sífilis y VIH

Staff initials: _____
(if box below is checked verify with patient)

IF YOU **DO NOT** WANT TO BE TESTED FOR HIV PLEASE MARK THIS BOX WITH AN X
SI USTED **NO DESEA** QUE SE LE HAGA LA PRUEBA DE VIH PORFAVOR MARQUE CON UNA X ☐

How did you hear about us? (¿Cómo escucho de nosotros?)

____Facebook ____ STDAZ.com ____Radio station; which station? _____
____ Internet; which website? _____ ____Other: _____

Official Use Only

BLOOD:

☐ **HIV 1/2 (Architect)**
Obtained, Consent provided
Not Obtained
Declined

☐ **Syphilis RPR**
Obtained
Not Obtained
Declined

SITE: Left Right
Antecubital Hand

Collected by: _____ **@** _____

GC/CT:

☐ Aptima Urine
☐ Aptima Rectal
☐ Aptima Vaginal

Collected by: _____ @ _____

Collected by: _____ @ _____

Phlebotomy Complications: Yes (explain below) No

_____
_____
_____
_____
_____

COMMENTS:

☐ Split tube for Syphilis/HIV
☐ Titer Only
☐ Titer & TP-PA

MARICOPA COUNTY DEPARTMENT OF PUBLIC HEALTH
DIVISION OF CLINICAL SERVICES
PATIENT RIGHTS AND RESPONSIBILITIES

We at MCDPH Clinical Services believe that your healthcare is a team effort. When you are well-informed, participate in your treatment decisions, and communicate openly and honestly with your care team, you can make help make your care as effective as possible.

The following are your rights and our responsibilities:

While you are under our care, we promise that:

- We will treat you with dignity, respect and consideration;
- We WILL NOT abuse, neglect, exploit, coerce, manipulate, sexually assault, or seclude you;
- We WILL NOT restrain you unless it is to prevent imminent harm to you or others;
- We WILL NOT retaliate against you for submitting a complaint to the Department or another entity;
- We WILL NOT misappropriate your personal or private property;
- We will obtain consent from you prior to providing treatment and allow you the opportunity to refuse or withdraw your consent prior to initiating treatment;
- We will inform you of the risks, complications and alternatives to a proposed psychotropic medication or surgical procedure;
- We will provide you with information regarding our policy on healthcare directives;
- We will provide you with information regarding our patient complaint process;
- We will obtain consent prior to taking a photograph of you unless that photograph will only be used for identification and administrative purposes; and that
- We will obtain written consent from you before releasing your medical or financial records unless otherwise permitted by law.

While you are under our care, you have the right to:

- Not be discriminated against regardless of your race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis; To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
- To receive privacy in treatment and care for personal needs;
- To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
- To receive a referral to another health care institution if the outpatient treatment center is unable to provide physical health services or behavioral health services for the patient;
- To participate or have the patient's representative participate in the development of, or decisions concerning treatment;
- To participate or refuse to participate in research or experimental treatment; and
- To receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights.

By signing below you acknowledge that you have received this information.

_____ _____

Signature Date