PCHR Guidelines and General Information

All Health Requirements are due by **July 15th**.

All PCHR forms are available on the Duquesne University Health Service website.

The Pre-Clinical Requirements Coordinator is located in Duquesne University Health Services (DUHS)
Phone 412-396-1650
Fax: 412-396-5655
Email: pchr@duq.edu
Address: Duquesne University Health Services (attn. Carol Dougher, RN)
2nd Floor Union
600 Forbes Avenue
Pittsburgh PA, 15282-1920

Duquesne University Health Services is able to provide:
- Physical Examination $50.00
- PPD (two-Step) $40.00
- PPD (Annually) $20.00
- Quantiferon Gold (Q-Gold) blood test —alternative to PPD— $90.00
- Blood/Laboratory Testing for Immunity:
  - Available titers: Measles/Mumps/Rubella, Hepatitis B, Hepatitis C, Varicella (Chicken Pox)

* Fees – Accepted forms of payment are cash, credit card or check payable to Duquesne University Health Service.
  *Fees are subject to change

Duquesne University Center for Pharmacy Care
- Immunizations can be obtained through the Duquesne University Center for Pharmacy Care.
  Appointments for immunizations can be scheduled by calling the center at 412-396-2155 or via email at cpc@duq.edu.
- Duquesne University Center for Pharmacy Care are providers with most major medical insurance carriers including the Student Health Insurance Plan (SHIP).

All PCHR documents must be submitted electronically to Health Services through the HEALTH SERVICE STUDENT PORTAL

Health Service Portal Access:
- Log into DORI
- In the “Services and Information” box Select HEALTH SERVICE STUDENT PORTAL
- Follow instructions in portal
Student’s Name: ___________________________________

Phone: ___________________ Date of Birth: __________

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**TUBERCULOSIS SCREENING (must be done annually)**

Use this form or attach a copy of the form of the facility where your PPD was given.

**PPD (Mantoux) Test**  (ALTERNATIVE: QUANTIFERON GOLD BLOOD TEST) PPD Date Read:

Induration (mm): ________  □Negative  □Positive

Read by: (PRINT) ___________________________ Signature: ____________________________

Name of Facility: ___________________________________ Phone Number: ______________________

If POSITIVE (10 mm. or more induration/or positive result Q Gold) please evaluate as follows:

1. Previous BCG Date: ______________
2. Chest X-ray Date: _______________ Results: __________________________ (attach copy of x-ray report)
3. INH Prophylaxis  □ No  □ Yes  Dosage: ___________________ Duration: ____________________

Follow – up or questions may be directed to: Allegheny County Health Department
Pulmonary Center
425 First Avenue, 1st Floor
Pittsburgh, PA 15219
(412) 578-8162

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**TETANUS**

If your last Tetanus booster was over 10 years ago, repeat and send a copy with this form.

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**PHYSICAL EXAM**

I have obtained a health history, performed a physical examination, and reviewed immunization status and laboratory results. In my estimation, this student has no physical, emotional, or mental limitations and is able to participate fully in student clinical activities in a health care or classroom setting.

(NOTE: ANY LIMITATIONS MUST BE DESCRIBED IN AN ATTACHMENT)

Examining Practitioner’s Signature: ___________________________ Date: __________________

Examining Practitioner’s Name: (PRINT) __________________________________________

Address: ___________________________ Telephone: ______________________

City: ___________________________ State: ______ Zip code: ______________________

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**INSTRUCTIONS**

Once form is completed, all PCHR documents need to be submitted electronically to Health Services through the Health Service Student Portal - gain access by: (Log into DOR>under Service and Information tab>select “HEALTH SERVICE STUDENT PORTAL”

Follow instructions in portal

**QUESTIONS ABOUT ITEMS ON HEALTH FORM**

Contact: Pre-Clinical Health Requirements Coordinator (PCHR)
University Health Service
Phone: 412-396-1650
Fax: 412-396-5655
Email: pchr@duq.edu

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Student should retain a copy of this completed form.

I give permission for information contained in this form to be shared with my individual school.

Student Signature ___________________________________ Date: __________________________
Seasonal Influenza Vaccine (Must be completed by October 15th)

Please complete and/or place sticker with information below

<table>
<thead>
<tr>
<th>Name of Vaccine:</th>
<th>Expiration Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manufacturer:</td>
<td>NDC#</td>
</tr>
<tr>
<td>Lot #</td>
<td>Date given:</td>
</tr>
</tbody>
</table>

| Health Care Provider Signature: |
| Address:          | City: | State: | Zip: |
| Phone number:     |