PRE-CLINICAL HEALTH REQUIREMENTS (PCHR) - RISING SENIORS

❖ 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: o 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: ________________

**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**
- Date Given: ________________  (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

**TETANUS**

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

**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 DORI)& 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

**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: ____________________
Annual Clinical Compliance

Seasonal Influenza Vaccine

Last name: ____________________  First name: ____________________  Middle initial: ____

Program: □ Basic BSN  □ Second Degree BSN

Seasonal Influenza Vaccine (Must be completed by October 15th)

<table>
<thead>
<tr>
<th>Please complete and/or place sticker with information below</th>
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<tbody>
<tr>
<td>Name of Vaccine: ____________________</td>
</tr>
<tr>
<td>Manufacturer: ____________________</td>
</tr>
<tr>
<td>Lot # ____________________</td>
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<tr>
<td>Health Care Provider Signature:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
</tbody>
</table>

Phone number:

THIS FORM AND ALL SUPPORTING DOCUMENTS MUST BE UPLOADED TO DU HEALTH SERVICE STUDENT PORTAL

INSTRUCTIONS TO UPLOAD TO HEALTH SERVICE STUDENT PORTAL