

Immunization and Consent Form

Clinic Site Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Patient and Insurance/Payment Information**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ Gender: (M)\_\_\_\_\_ (F)\_\_\_\_\_Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 Digits Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Plan Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Secondary Insurance (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Other Payment – if not billing insurance:**Cash \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Check\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Credit Card\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **PATIENT SCREENING INFORMATION – to be completed with the Nurse.**If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked to help us determine which vaccines you may be given today.

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|  | Yes | No | Don’t Know | Comments: |
| **INFLUENZA ONLY ------------------------------------------------------------------------------------------------**  | ----- | ------ | -------- |
| 1. Are you sick today? |  |  |  |
| 2. Do you have allergies to medications, egg, vaccines, or latex? |  |  |  |
| 3. Have you ever had a serious reaction after receiving a vaccine? |  |  |  |
| 4. Have you had a seizure, a brain or nervous system problem or Guillain-Barre Syndrome? |  |  |  |
| 5. Have you received a vaccine in the last 4 weeks? |  |  |  |
| **OTHER IMMUNIZATIONS** |  |  |  |
| 6. For women: Are you pregnant or is there a chance you could become pregnant during the next month? |  |  |  |
| 7. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease, anemia or other blood disorder? |  |  |  |
| 8. Do you or anyone living in your household have cancer, leukemia, HIV/AIDS or any other immune system problem? |  |  |  |
| 9. Do you have any problems with your immune system or take medications which affect your immune system? |  |  |  |
| 10. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? |  |  |  |

(**Patient**) Questions answered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(**Nurse**) Responses Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contraindications present? Yes/No If **Yes**, explain: |

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| **Patient Consent to Administer and Financial Responsibility*** I have had a chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits and the risks and ask that the vaccine or injection be given to me or to the person named for whom I am authorized to make this request.
* I have received a copy of the Vaccine Information Statement (VIS) for the vaccine that I will receive today. I have read or have had explained to me the information provided to me regarding the vaccines I will be receiving. I understand that I will need additional doses of the Shingles, Hepatitis, Chicken Pox, Meningococcal B and/or Human Papilloma vaccines for long term protection.

\_\_ Influenza (One dose)\_\_ Twinrix: Hepatitis A and Hepatitis B Combo- (Two additional doses required at one and six months)\_\_ Havrix: Hepatitis A ***Pediatric***- 720ELU/ml (One additional dose required at six to twelve months later)\_\_ VAQTA: Hepatitis A **Adult**- (One additional dose required six to eighteen months later)\_\_ Energix-B: Hepatitis B ***Pediatric***- 10mcg/0.5ml (Two additional doses required at one month & six month later)\_\_ Energix-B Hepatitis B **Adult**- 20mcg/1.0ml (Two additional doses required at one month and six months)\_\_ Gardasil 9 Human Papilloma (HPV)- (One/Two additional doses required depending on age)\_\_ MMR II Measles, Mumps, Rubella- (One dose)\_\_ Menveo: Meningococcal ACWY- (One dose)\_\_ Bexsero: Meningococcal B- (2 doses at least one month apart)\_\_ Prevnar 13: Pneumonia conjugate (PCV13) - (One dose)\_\_ Pneumovax 23: Pneumonia polysaccharide (PPSV23) - (One dose)\_\_ Shingrix: Shingles- (One additional dose required two to six months later)\_\_ Tetanus, Diphtheria (Td) (One dose)\_\_ Boostrix: Tetanus, Diphtheria, Pertussis (Tdap)- (One dose) \_\_ Varivax: Chicken Pox (Varicella)- (One additional dose at one month)\_\_ Other Vaccine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* I have received a copy of the Notice of Privacy Practices.
* Financial Responsibility:

By my signature below, I acknowledge that I have received the vaccine as indicated and I authorize my provider to bill and collect from my insurance for the vaccine and related administration fees. I understand that this authorization does not release me from any financial responsibilities (co-payments or deductibles) required under my plan. I have been notified that my insurance may deny payment entirely or partially for the vaccine or injection. If my insurance denies payment for the entire amount or for a partial amount, I agree to be personally and fully responsible for payment.Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Billing Form: to be completed by the Nurse**

1. **Vaccines Administered Patient Name:­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Flulaval PFS**- Quad Pres Free (age 6 mo+)   | \_\_\_\_\_ 90686 | **Havrix** 720ELU/0.5ml Hepatitis A **Pediatrics** (ages 1+, 2 doses 0, 6-12 mo) | \_\_\_\_ 90633  |
| **Flucelvax PFS**- Quad Pres/Egg Free (ages 18+)   | \_\_\_\_\_ 90674 | **Energix-B** 10mccg/0.5- Hepatitis B **Pediatrics** (ages 0-19, 3 doses 0, 1, 6 mo) | \_\_\_\_ 90744  |
| **Flucelvax MDV**- Quad Egg Free (ages 18+)  | \_\_\_\_\_ 90756 |  |  |
| **Fluad** - HD Flu (ages 65+)  | \_\_\_\_\_ 90653 | **Varivax**- Chicken Pox (ages 13+, 2 doses 4-8 weeks apart | \_\_\_\_\_ 90716  |
| **Shingrix**- Shingles (ages 50+, 2 doses 0, 2-6 mo)  | \_\_\_\_\_\_ 90750  |  |  |
| **Prevnar 13**- PCV13 (ages 18+)  | \_\_\_\_\_ 90670  | **Gardasil 9**- HPV (ages 15-45, 3 doses 0, 2, 6 mo) | \_\_\_\_\_ 90651 |
| **Pneumovax 23**- PPSV23 (ages 65+ or w/chronic illness) | \_\_\_\_\_ 90732 |  |  |
| **Boostrix**- TDAP/Tetanus Diphtheria Pertussis (ages 10+ ) | \_\_\_\_\_ 90715 | **Menveo**- Meningitis ACWY (ages 2 mo- 55 yrs)  | \_\_\_\_\_ 90734 |
| **MMR II**- Measles Mumps Rubella (ages 12 mo+)  | \_\_\_\_\_ 90707 | **Bexsero**- Meningitis B (ages 10-25, 2 doses 1 month apart)  | \_\_\_\_\_ 90620  |
| **Twinrix**- Hep A & Hep B (ages 18+, 3 doses 0, 1, 6 mo)  | \_\_\_\_\_ 90636  |  |  |
| **Energix- B** 20mccg/1.0ml- Hepatitis B **Adults** (ages 19+, 3 doses 0, 1, 6 mo) | \_\_\_\_\_ 90746 | **Other Vaccine**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ CPT |
| **Havrix** 1440 ELU/1.0 ml Hepatitis A **Adults** (ages 19+, 2 doses 0, 6-12 mo) **VAQTA–** Hep A Adult |  \_\_\_\_ 90632 | **Other Vaccine**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ CPT |

1. **Codes for Administration of Vaccine**

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| Administration, 1 vaccine  | \_\_\_\_\_ 90471  | \_\_\_\_\_ G0008 | **MEDICARE**- **Any Flu** Administration |
| Administration, each additional vaccine  |  \_\_\_\_\_ 90472 | \_\_\_\_\_ G0009 | **MEDICARE**- **Any** **Pneumonia**  |
|  |  | \_\_\_\_\_ G0010 | **MEDICARE**- **Hep B** Administration  |

1. **Vaccine Administration Record**

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| **Vaccine** | **Date Administered** | **Site and Route** | **Manufacturer / Lot No.** | **Current VIS Date** | **Date VIS given to patient** |
| **Influenza** |  | RD LDIM SC |  | 08/15/2019 |  |
| **Twinrix**Hep A & Hep B |  | RD LDIM SC |  |  07/20/201608/15/2019 |  |
| **Havrix for Pediatrics & Adults** Hepatitis A  |  | RD LDIM SC |  | 07/20/2016 |  |
| **Energix for Pediatrics & Adults** Hepatitis B  |  | RD LDIM SC |  | 08/15/2019 |  |
| **Gardasil 9**HPV  |  | RD LDIM SC |  | 10/30/2019 |  |
| **MMR II** Measles, Mumps, Rubella |  | RD LDIM SC |  | 08/15/2019 |  |
| **Menveo**Meningitis ACWY |  | RD LDIM SC |  | 08/15/2019 |  |
| **Bexsero**Meningitis B |  | RD LDIM SC |  | 08/15/2019 |  |
| **Prevnar 13** Pneumonia conjugate PCV13 |  | RD LDIM SC |  | 10/30/2019 |  |
| **Pneumovax 23**Pneumonia polysaccharide PPSV23 |  | RD LDIM SC |  | 10/30/2019 |  |
| **Shingrix**Shingles |  | RD LDIM SC |  | 10/30/2019 |  |
| **Boostrix**Tdap  |  | RD LDIM SC |  | 04/01/2020 |  |
| **Varivax**Chicken Pox |  | RD LDIM SC |  | 08/15/2019 |  |
| **Other** |  | RD LDIM SC |  |  |  |

Vaccine(s) administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title: \_\_\_\_\_\_\_\_\_\_\_\_\_ Revised 10/06/2020 (Nurse Signature)