Influenza (TIV) Vaccination Administration Record

WSU Eugene Applebaum College of Pharmacy APhA-ASP Chapter
2009 WSU Faculty Flu Clinics

LAST NAME OF PATIENT *(print clearly)*	FIRST NAME	MI

MAILING ADDRESS	CITY

STATE	ZIP CODE	HOME PHONE #	DATE OF BIRTH mm/dd/yy	AGE	GENDER
		( )			☐ M ☐ F

Read the following questions and check the box that applies	**YES**	**NO**
1. Are you sick with a fever? Or feeling severely ill today?		
2. Have you had an adverse reaction (i.e. requiring medical attention) to any vaccine in the past?		
3. Are you allergic to chicken eggs, latex or thimerosal(a preservative found in eye drops)?		
4. Do you take cortisone, prednisone, other steroid, anticancer medications, or have had x-ray treatments?		
5. Do you have cancer, leukemia, HIV, AIDS, or any other immune system problem?		
6. Do you have an active nerve disorder like MS, Parkinson's, or Lou Gehrigs' disease?		
7. Do you have a history of developing Guillain-Barre syndrome?		
8. For women: Are you pregnant or is there a chance that you could be pregnant?		

9. Who is your primary care physician? Name:____
Phone #:____
Address:____

I have received and read/had explained to me the Vaccine Information Statement(s) (VIS) on the vaccine(s) to the given. I had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks. I request that the vaccine(s) be given to me or the person named above for whom I am authorized to make this request. I agree that University Pharmacy shall have no responsibility or liability if I contract influenza, other respiratory diseases, or suffer any other adverse reaction following administration of my shots. In addition (for those to whom it applies). I ask that payment of authorized Medicare/HMO benefits be made on my behalf to University Pharmacy for the immunization administered to me. I am authorizing any holder of medical or other information about myself to be released to CMS, MCIR and its agents, including my information needed to determine any and all benefits for related services. I acknowledge a receipt for privacy notice.

Signature of Patient or Responsible Person:__________________________________ **Date:**___________

Circle relationship to employee: SELF SPOUSE CHILD

********************* **FOR CLINIC USE ONLY** ***

Influenza Vaccine (TIV)	**University Pharmacy**	**For HMO Purpose Only**	**Payment Information**
Dose: 0.5 mL Route: IM Syringe: 23G/ 1 cc/ 1" 1.5" Syringe: 25G/ 1 cc/1" 1.5" Manufacturer: □ **Afluria® PFS -(CSL)** (thimerosol & latex free) □ **Fluvirin® PFS -(Novartis)** (latex-free) □ **Fluarix® PFS- (GSK)** (contains latex) Lot #: _______________ Exp: ________________ Circle Inj Site: L R Deltoid	Pharmacist ☐ Intern: ☐ __________________ Circle: Influenza VIS (rev 2009-2010) given to patient and vaccine administered on: Date: ____/____/_____ Time: _______am /pm	FT ID: 87-0765555 Diagnosis Code: V04.81 Procedure Code: 90658 Administration Code: G0008 Service Location: Community Provider Suffix Code: 01 Remit Payment to: University Pharmacy 5254 Anthony Wayne Drive Detroit, MI 48202 313-831-2008	□ **Check #**________ **$**__________ □ **Cash Amount: $**_________ □ **Third Party Payer/Insurance** □ BCN □ HAP □ Total Health Care □ DMC □ BCBSM – Med Students Employer Name: ________________ Bin#: ____________________ PCN #: ___________________ **ID #:** ____________________ RX Group #: ______________