

Patient Name: _____ DOB: _____ Patient age: _____

Adult Influenza Screening Form

2020-2021 Influenza Vaccine– Screening (Adult)

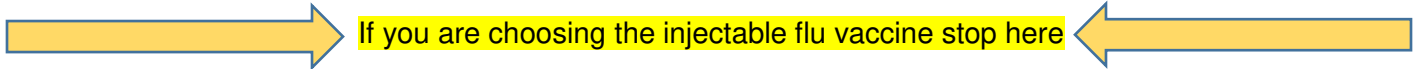
Please choose which insurance to bill: Insurance 1 Insurance 2 Insurance 3

Other: _____

For Injectable Vaccine - Please check YES or NO for each question

	NO	YES
1. Have you ever had a serious reaction to a flu vaccine in the past?		
2. Have you ever had a serious allergic reaction after eating eggs?		
3. Do you have an allergy to gentamicin, neomycin, polymyxin or gelatin?		
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

Please explain any 'Yes' responses. _____



If you are choosing the injectable flu vaccine stop here

If you would like the Live Attenuated Intranasal Influenza Vaccine (Spray) -- Please check YES or NO for each question

For use with people age 2 through 49 years: The following questions will help us determine if there is any reason we should not give you live attenuated intranasal influenza vaccine (LAIV, FluMist) today. If you answer "yes" to any questions, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please speak to a nurse.

If you respond 'Yes' to any of the questions, please explain in the space provided below.

	NO	YES
1. Do you have any allergies to medication, foods, or any vaccines?		
2. Do you have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes), or have a cochlear implant or spinal fluid leak, or no spleen?		
3. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have you taken medications that affect the immune system (e.g., prednisone or other steroids, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis, or anticancer drugs) or have you had radiation treatments?		
4. Are you taking influenza antiviral medications?		
5. Are you pregnant or could become pregnant within the next month?		
6. Have you received any other vaccinations in the past 4 weeks?		

Please explain any 'Yes' responses. _____

Patient Name: _____ Patient age: _____

OFFICE USE BELOW

E. To be completed by person administering vaccine:

Screening Reviewed and Education Provided by: _____

Vaccination Date:		Payer Source		Codes	
EIPH Office: 1250 Hollipark Drive Idaho Falls, ID 83401 (208)533-3235		Insurance Medicare State Supplied Adult		90471 G0008 90472 G0009 <div style="text-align: right;">Nasal</div>	
Vaccine	Lot Number	Provider Name		Site	Route
90686	Fluarix (Quad)			Left or Right Deltoid	IM
90688	Fluzone (Quad) MDV			Left or Right Deltoid	IM
90674	Flucelvax (Quad)			Left or Right Deltoid	IM
90682	Flublok (Quad)			Left or Right Deltoid	IM
90662	HD Flu			Left or Right Deltoid	IM
90672	Fllumist			Nasal	Intranasal
90715	Tdap			Left or Right Deltoid	IM
90670	Pprevnar			Left or Right Deltoid	IM
90732	PPSV23			Left or Right Deltoid	IM
90674	Flucelvax (Quad) (317)			Left or Right Deltoid	IM
90715	Tdap (317)			Left or Right Deltoid	IM
90670	Pprevnar (317)			Left or Right Deltoid	IM
90732	PPSV23 (317)			Left or Right Deltoid	IM
	Other				

Checked In ☐
 Scanned ☐
 SuperBilled ☐
 Checked out ☐