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** **Nasal**	
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	**Prevnar**			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	**Prevnar (317)**			Left or Right Deltoid	IM
90732	**PPSV23 (317)**			Left or Right Deltoid	IM
	Other				

Checked In ☐ Scanned ☐ SuperBilled ☐ Checked out ☐

NS 09/2020