Avance Care – Influenza Injectable Immunization Questionnaire/Consent Form

Today's Date*		**Instruction:** *Established patients with current insurance on our file only need to provide information in shaded area.*

PATIENT INFORMATION

Patient Name*	Date of Birth*	Marital Status* ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	Gender* ☐ M ☐ F
Address*			
Home Phone*	Cell Phone*	E-Mail Address*	

GUARDIAN/GUARANTOR INFORMATION (Only for Patient under 18 years of age - List person responsible for bill – use full legal name, no nicknames)

Name	Date of Birth	Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other (please specify)	Gender ☐ M ☐ F

INSURANCE INFORMATION (Please allow receptionist to photocopy your insurance ID cards)

Insurance Name* *(if paying cash, please indicate "Self-Pay")*	Policy ID #	Group No.	Effective Date:
Subscriber Name	Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other (please specify)	Date of Birth	

EMERGENCY INFORMATION

Person to Notify in Case of Emergency	Primary Phone	Alternate Phone

QUESTIONNAIRE (*To Be Filled by All Patients*)

The following questions will help us determine if there is any reason we should not give you or your child an injectable influenza vaccination today. If you answer "yes' to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask us to explain.

1. Is the person to be vaccinated sick today? ☐ Yes ☐ No
   If yes: Does the patient have a fever? ☐ Yes ☐ No
2. Does the person to be vaccinated have any allergies? ☐ Yes ☐ No
   If yes, what:_____
3. Does the person to be vaccinated today have or ever had:
   a. an allergy to egg protein? ☐ Yes ☐ No
   b. a sensitivity to Thimerosal, a preservative used in vaccines, or gelatin? ☐ Yes ☐ No
   c. a sensitivity to latex rubber? ☐ Yes ☐ No
   d. a serious allergic reaction or other problems after getting an Influenza (Flu) Vaccine? ☐ Yes ☐ No
   e. a history of Guillain-Barre Syndrome (GBS)? ☐ Yes ☐ No
   f. an active neurological disorder? ☐ Yes ☐ No
   g. a bleeding disorder(hemophilia or thrombocytopenia) or is he/she on anticoagulant therapy? ☐ Yes ☐ No
4. Is the person to be vaccinated immunocompromised (i.e. HIV positive) or taking immunosuppressive medication (i.e. on steroids, a transplant patient)? ☐ Yes ☐ No
5. If the person to be vaccinated is female, are they pregnant? ☐ Yes ☐ No
6. If the person to be vaccinated is a child, are they less than 6 months of age? ☐ Yes ☐ No
7. If the person to be vaccinated is a child, are they less than 9 years of age? ☐ Yes ☐ No
   a. If yes for #7, have they received an influenza vaccine in the past? ☐ Yes ☐ No

AUTHORIZATION

I authorize the release of any information concerning my or my child's health care, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Avance Care, P.A.

CONSENT TO TREATMENT

I hereby consent to evaluation, testing and treatment for me or my dependents as directed by my physician or his or her designee at Avance Care, P.A.

INFLUENZA INJECTABLE IMMUNIZATION CONSENT

I have read the vaccine information statement and have had a chance to ask questions that were answered to my satisfaction. I understand the risks and benefits of the influenza vaccine. I understand that I will be asked to stay up to 20 minutes after I receive my flu shot. I ask that the influenza vaccine be given to me.

Signature of Patient or Parent of minor or Legal Guardian:	Name	Date

HEALTHCARE PROVIDER SECTION

☐ Above questionnaire reviewed ☐ Influenza VIS given ☐ Questions answered ☐ Quadrivalent ☐ High Dose

Date Given	Manufacturer	Lot #	Site	Dosage	Provider Signature
	Sanofi-pasteur		RD LD	0.5 ml 0.25ml	_____

This administration information was entered into the electronic medical record: ☐ Yes ☐ No