

Save time and complete the **Patient Information** portion of our Flu **Administration Record** and the **entire Questionnaire** in advance. Please print it and bring it with you to the pharmacy when you stop by for your flu shot.

2014-2015 INFLUENZA VACCINE
ADMINISTRATION RECORD

METHOD OF PAYMENT: CASH PRESCRIPTION PLAN (PHARMACY BENEFIT) MAJOR MEDICAL

MEDICARE "B" (E-RX) MEDICARE #: _____
OR
 MEDICARE REPLACEMENT (ALL) or PRIVATE INSURANCE/MAJOR MEDICAL (CIGNA, MEDICAL MUTUAL and SUMMA ONLY- NO ANTHEM MAJ MED). PLAN _____
CLAIM ADDRESS: _____
ID# _____ GROUP#: _____
RELATIONSHIP TO CARD HOLDER (Circle one): SELF SPOUSE DEPENDENT

* Have Medicare card/Medicare Replacement card available for confirmation. *

For **MEDICARE** or **INSURANCE** recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to Discount Drug Mart. We will attempt to bill all claims through the "on-line" insurance system. If a claim rejects, we will charge cash. For patient reimbursement, the patient must submit their Cash Receipt to their major medical benefits provider.

PATIENT INFORMATION: *(Permanent home information)*****

NAME: LAST: _____ FIRST: _____ M.I. _____
ADDRESS: _____ CITY: _____ STATE: _____
ZIP: _____ COUNTY: _____ PHONE #: _____
SEX: M _____ F _____ DATE OF BIRTH: _____ WT: _____
CHRONIC ILLNESS? YES _____ NO _____
FAMILY PHYSICIAN: _____

Amount being submitted on your behalf:
Flu Vaccine + Administration of Vaccine-\$30.00*
FluMist + Administration of Vaccine - \$45.00*
Fluzone HD + Administration of Vaccine - \$50.00*
*estimate only

ICD-9 : V04.81

Physician On Record:
Joyce Lender
1268 East Broad St., Suite # 1
Elyria, Ohio 44035

I have read or have had explained to me the information in the important information statement about influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request.

SIGNATURE AUTHORIZING VACCINATION: _____ **Date:** _____

(Person receiving vaccination or guardian or parent making request.)

PATIENT RECEIVED NOPP FORM: Pt Initials (_____)

PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THIS FORM.

*****DO NOT WRITE BELOW THIS LINE*****

DISCOUNT DRUG MART - STORE # _____ DATE ADMINISTERED: _____
VACCINE MANUFACTURER: (Circle one) Sanofi Novartis MedImmune Glaxo Merck
LOT #: _____ DOSE: 0.5 ml NOTES: _____
INJECTION SITE/GAUGE/LENGTH: L. Arm R. Arm 25 G 1 in 25G 5/8 in Other: _____
Vaccine Administrator: Signature: _____ Title: _____

ENTER INTO PIONEER BY USING THE E-RX OR OTHER BILLING CODES. KEEP ONE COPY OF FORM AT STORE. IF BILLING PRIVATE, MAJOR MEDICAL, MEDICARE OR MEDICARE REPLACEMENT SEND ONE COPY TO HHC BILLING, ATTN; CRIS W.

Patient Name: _____

Today's Date: _____

Date of Birth: _____

Screening Questionnaire for Adult Influenza Immunizations

This form helps us to decide which vaccines should be given in the pharmacy today. Please answer the following questions. Please see the pharmacist when completed.

1. Did you have a flu vaccine last year? Yes or No

2. Are you sick today?
(If you are currently sick enough to go to the doctor or emergency room, you should postpone receiving a flu vaccine.) Yes or No

3. Do you have allergies to medications? Yes or No

4. Do you have allergies to eggs, any vaccine component? Yes or No

5. Have you ever had a serious reaction after receiving a vaccine? Yes or No

6. Do you, any person who lives with you, or any person you take care of, have cancer, leukemia, AIDS, or any other immune system problem?
(Answering "Yes" is an extra reason to receive a flu vaccine.) Yes or No

7. Do you, any person who lives with you or any person you take care of, take cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatments?
(Answering "Yes" is an extra reason to receive a flu vaccine.) Yes or No

8. During the past year, have you received a transfusion of blood or plasma, or been given a medicine called immune globulin? Yes or No

9. For women: Is it possible that you are pregnant or may become pregnant in the next three months?
(Note: Influenza vaccines are recommended in pregnancy) Yes or No

If you don't have an immunization record card with you, let the pharmacist know. Bring this card with you to your clinic and immunization visits. Make sure your vaccinations are recorded on it.