Screening Form for Adult Non-Influenza Immunizations

Date: _____

Name: _____ **DOB**: _____ **Over 65?** Y N Male Female
Last First MI

Address: _____
Street City State Zip

Phone:( ) _____ **Doctor's Name & Clinic**: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS **BEFORE** RECEIVING YOUR VACCINE:

	Yes	No	Unsure
1. Are you **sick** today?	☐	☐	☐
2. Do you have **allergies** to medications, food, any vaccine, gelatin, neomycin, or latex? [A]	☐	☐	☐
3. Have you ever had a serious **reaction** after receiving a vaccination? [B]	☐	☐	☐
4. Do you have cancer, leukemia, HIV / AIDS, or any other **immune system problem**? [C]	☐	☐	☐
5. Do you take prednisone, or other **steroids**, or **anticancer or antiviral drugs**, or have you had radiation treatments? [D]	☐	☐	☐
6. Have you had a seizure or a brain or another **nervous system disorder**? [E]	☐	☐	☐
7. During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
8. **Women**: Are you **pregnant** or could you become pregnant during the next month? [F]	☐	☐	☐
9. Have you received any vaccinations in the **past 4 weeks**? [G]	☐	☐	☐

My signature below indicates that I have read and understand all the information provided to me about the vaccine and that I have answered the above questions truthfully.

Patient Signature _____ Date:_____

CASH PAYING PATIENTS

My signature below verifies that to the best of my knowledge, the vaccine I am receiving today could **NOT** be paid by any other source such as employer sponsored health plan, federal grant or black lung program or I have chosen to pay cash even if the vaccine is covered by my private medical insurance.

Patient Signature _____ Date:_____ ☐ ***Paid?***

INSURANCE PATIENTS (Medicare Part **B:** Pneumococcal, Medicare Part **D:** Tdap,Td, Zoster**)**

Insurance Number:_____ MR#:_____(ask pharmacy staff if not known)

****PHARMACY USE ONLY****

Vaccine: Pneumococcal Td Tdap Zoster *(please circle)* **Amount injected**: 0.5ml 0.65 ml given SQ IM
Arm: L R **VIS** provided? Yes No (Pub. Date: _____) Mfr:_____
Exp Date:_____Lot #:_____Given by: _____ RPh / Pharm.D./Student
Supervising Rph: _____

A. If **yes** to gelatin or neomycin allergies, patient should not receive **Zoster** vaccine. If **yes** to latex allergy, patient should not receive **vaccine** from a pre-filled syringe.
B. If severe pain/swelling, coma, or seizures within 7 days of DTAP or DTaP, do not administer **vaccine**.
C. If **yes**, refer patient to primary care provider if they are requesting **Zoster** vaccine.
D. If **yes**, postpone **Zoster** until chemo or high-dose steroid therapy has ended.
E. If **yes**, do not administer Td or **Tdap** vaccine.
F. If **yes**, do not administer **Zoster** vaccine.
G. If **yes** and the patient received a **live vaccine** (LAIV, MMR, Varicella, yellow fever), they should wait 28 days if requesting **Zoster** vaccine. Of note, **Zoster** vaccine administration should be separated from **Pneumococcal** vaccine administration by 28 days when possible.

Faxed to Central Ops (203-4900): □ Documented in WIR: □ Billing completed: □ (if necessary) Last Updated:(7/17)