

# Flu Immunization 2006-2007

(888) 547-7295 or (734) 477-7229



Vaccine Code: 90658/90655 Tax ID: 38-2693137  
 Admin Code: G0008 ICD-9: V04.81  
 MD order signed: Dr. Lourdes Velez  
 Vaccination Fee: \$33.00 / \$34.00

## To Be Completed by ALL PATIENTS

LEGAL Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Weight: \_\_\_\_\_ lbs  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male / Female Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Please see your doctor or health care clinic regarding a flu shot if you have any of the following conditions or allergies:**  
**Allergies:** allergic to eggs or egg products, allergic to thimerosal (preservative), allergic to LATEX, allergic to Benadryl or epinephrine  
**Conditions:** are running a fever of 101°F, had Guillain-Barré Syndrome

### Please circle your answer on the right side of the page.

- |   |    |     |
|---|----|-----|
| 1. Are you sick today or are you running a temperature of 101° F or over?                                       | No | Yes |
| 2. Are you allergic to eggs or egg products?  | No | Yes |
| 3. Are you allergic to LATEX?   | No | Yes |
| 4. Are you allergic to thimerosal (in some prescription eye/ear drops, topical medicines and vaccines)?         | No | Yes |
| 5. Are you allergic to merthiolate?   | No | Yes |
| 6. Have you ever been diagnosed with Guillain-Barre Syndrome?   | No | Yes |
| 7. Are you allergic to Benadryl or epinephrine?   | No | Yes |
| 8. Did you begin taking an antibiotic yesterday or today?   | No | Yes |
| 9. Do you take Coumadin or warfarin?  | No | Yes |
| 10. Have you had another immunization in the last 14 days?  | No | Yes |
| 11. Have you ever had a reaction to a flu shot (sore arm, shortness of breath, etc.)?                           | No | Yes |
| 12. Have you ever had a <u>severe</u> allergic reaction to <u>anything</u> (taken medication/gone to hospital)? | No | Yes |
| 13. Have you had a flu shot in the last three years?  | No | Yes |
| 14. Have you ever been seen by any University of Michigan physician (including in the ER)?                      | No | Yes |

### PATIENT CONSENT

I have read the information sheet about influenza (the flu) and influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. The information I have provided above is correct and true to my knowledge. I believe I understand the benefits and risks of influenza vaccination and request that the vaccine be given to me or to the person listed below, for whom I am authorized to make this request. If Medicare denies payment, or my original method of payment is rejected, I agree to be personally responsible for full payment.

Signature of person to receive vaccine. \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of person authorized for patient listed above (if under 18 yrs of age or physically unable) \_\_\_\_\_

I have been provided with a copy of the Notice of Privacy Practice.

## To Be Completed by MVN CLINIC STAFF

Immunization site: IM  Deltoid  Thigh  Left  Right  
 Manufacturer:  sanofi Aventis  sanofi P-free  Novartis  GSK  
 Lot number: \_\_\_\_\_ Nurse: \_\_\_\_\_  
 Temperature  Not Approved  Referred  VNA patient  VC patient  VNA/VC family

These questions determine how you are receiving your **Medicare benefits**.

- |  |    |     |
|--|----|-----|
| 1. Are you over the age of 65? If NO, skip to question 4.....  | No | Yes |
| 2. Are you covered by another Health Plan or HMO other than Medicare. IF so, does Medicare pay first?....  | No | Yes |
| 3. Do you have Medicare due to a Non-Work Related Accident/Condition, Black Lung (BL) Benefits, End Stage Renal Disease (ESRD), or coverage other than traditional Medicare? ..... | No | Yes |
| 4. Are you a Disabled Medicare Beneficiary under the age of 65? .....  | No | Yes |
| 5. Do you have Medicare due to a Work Related Accident/Condition (WC plan, DVA or Federal BL Pgm)? .....   | No | Yes |

Cash, Check, Credit Card, Medicare part B, CareChoices, HAP, MCare or UM Student Account payment required. MVN does NOT bill other insurances. Patients may seek reimbursement from their insurance company. MVN does NOT guarantee reimbursement.

Medicare is the PRIMARY insurance. Secondary insurance is: \_\_\_\_\_

Medicare number and letter(s) are: \_\_\_\_\_

CareChoices  HAP  MCare

Insurance GROUP number: \_\_\_\_\_

Insurance ID number: \_\_\_\_\_

Credit Card and UM Student Account payments must be completed on separate credit card authorization form.

Fee Paid: \_\_\_\_\_  
 Cash  
 Check  
 Credit Card  
 Medicare  
 CareChoices  
 HAP  
 MCare  
 MVN Voucher  
 Employer  
 MVN Staff  
 Other