

# “Seasonal” Influenza Immunization Questionnaire

rev: 10/08/11

For patients: The following questions will help us determine if you are eligible to receive seasonal influenza vaccine today. Please answer these questions by checking the boxes. If the question is not clear, please ask us to explain it. This product contains thimerosal (a mercury based preservative) and cannot be administered to pregnant women or children less than 3 years of age.

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ Age (years) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_  
 Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

## Do you have Medicare Part B or a Medicare Advantage Plan? We need your card!

		YES	NO	DON'T KNOW
1.	Have you received an influenza vaccine <b>August 2011 or later?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you have a <u>severe</u> allergy to eggs or egg products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Do you have an allergy to thimerosal (a mercury based preservative)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you have a history of Guillain-Barre Syndrome? <small>(An auto-immune disorder affecting part of the nervous system causing weakness &amp; paralysis)</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Consent for immunization:**

As the patient, (or parent or guardian of minor patient), I have read the Vaccine Information Statement (7/26/11 version) and understand the benefits and risks of receiving influenza vaccine. I have discussed the above questionnaire with the representative from Ostroms and qualify for immunization. I hereby request the certified representative of Ostroms Drugs to administer influenza vaccine to me (or my minor) today. **DSHS recipients: I understand that Ostroms does not bill DSHS for this service and I understand that I cannot submit billing directly.** Private insurance patients: I understand that Ostroms does not bill all insurance companies for this service but I can submit receipts directly, although there is no guarantee of payment. I will not hold Ostroms, its personnel or supervising physician liable for any adverse effects resulting from administration of this vaccine.

**Medicare Authorization To Bill:** I understand that I am giving Ostrom Drugs permission to ask Medicare for payments for my immunization and its administration. Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payments requests. The Centers for Medicare and Medicaid Services (CMS) is the government's Medicare agency. A photocopy of this release is as valid as the original document. I am responsible for paying any deductible or co-insurance copays. Therefore, I ask that payment of authorized Medicare be made on my behalf to Ostrom Drugs for immunization and administration services. I authorize Ostroms to release medical information to CMS as needed to determine these benefits and related services.

\_\_\_\_\_  
 Patient (or Guardian) Signature

\_\_\_\_\_  
 Date

**DO NOT WRITE BELOW THIS LINE**  
**Administration & Payment Record**

Influenza Virus vaccine (Fluzone) Purified Surface Antigen Vaccine 2011-2012 Formula NDC# 49281-0388-15 Lot: UH453AC Exp: 6/30/12	Admin Date ___ / ___ / 2011 Admin By WB ___ CP ___ GG ___ DC ___ AB ___												
<table style="width: 100%; border: none;"> <tr> <td style="border: none;"><b>Medicare Pt</b></td> <td style="border: none;"><b>Yes</b></td> <td style="border: none;"><b>No</b></td> <td style="border: none;"><b>Billed?</b></td> <td style="border: none;"><b>Yes</b></td> <td style="border: none;"><b>No</b></td> </tr> <tr> <td style="border: none;"><b>Cash Pt</b></td> <td style="border: none;"><b>Pd Amt</b></td> <td colspan="4" style="border: none;"><b>Init</b></td> </tr> </table>	<b>Medicare Pt</b>	<b>Yes</b>	<b>No</b>	<b>Billed?</b>	<b>Yes</b>	<b>No</b>	<b>Cash Pt</b>	<b>Pd Amt</b>	<b>Init</b>				Dose: 0.5ml      Route: Intra-muscular Rt Arm      Left Arm      Right Thigh      Left Thigh
<b>Medicare Pt</b>	<b>Yes</b>	<b>No</b>	<b>Billed?</b>	<b>Yes</b>	<b>No</b>								
<b>Cash Pt</b>	<b>Pd Amt</b>	<b>Init</b>											

Fee \$25.00

