

H1N1 - PATIENTS 50 YEARS AND OLDER

"H1N1" Influenza Immunization Questionnaire

rev: 12/9/09

For patients: The following questions will help us determine if you are eligible to receive seasonal influenza vaccine today. **This vaccine does not protect against seasonal influenza.** Please answer these questions by checking the boxes. If the question is not clear, please ask us to explain it. **This vaccine contains thimerosal (a mercury based preservative).**

Patient Name _____ Date of Birth _____

Address _____ Age (years) _____

City _____ State _____ Zip Code _____ Phone _____

Physician Name _____ Phone _____

If you have Medicare or a Medicare Advantage plan, please present your card with this form.

		YES	NO	DON'T KNOW
1.	Do you have Medicare or Medicare Advantage? (we need your card)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you received an H1N1 vaccination this season?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Do you have a severe allergy to eggs or egg products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Are you taking any antiviral medication (Tamiflu, Relenza, amantadine)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have an allergy to thimerosal (a mercury based preservative)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Do you have a history of Guillain-Barre Syndrome? (An auto-immune disorder affecting part of the nervous system causing weakness & paralysis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Consent for immunization:

As the patient, I have read the Vaccine Information Statement (10/2/09 version) and understand the benefits and risks of receiving H1N1 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 today. **DSHS recipients: I understand that Ostroms does not bill DSHS for this service and I understand that I cannot submit billing directly.** I agree to pay the administration fee and understand it will not be reimbursed. **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 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 (CMS) and the companies that handle Medicare payments requests. 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. If I choose to pay for this service, I understand that Medicare billing & possible reimbursement cannot be done at a later time. I authorize Ostroms to release medical information to CMS as needed to determine these benefits and related services.

Patient Signature

Date

DO NOT WRITE BELOW THIS LINE

Influenza A (H1N1) Monovalent Vaccine (Fluvirin) NDC# 66521-0112-10 Lot: UP024AA Exp: 4/16/11	Admin Date ____ / ____ / 2009 Admin By WB ____ CP ____ GG ____ DC ____
<input type="checkbox"/> Medicare Part B <i>copy of card attached</i>	<input type="checkbox"/> Medicare Advantage <i>copy of card attached</i>
<input type="checkbox"/> Cash (\$20.00) Paid	Dose: 0.5ml Route: Intra-muscular Rt Arm Left Arm Right Thigh Left Thigh

!20000010016!