☐ **Cash/Check** ☐ **Medicare** ☐__________ ☐ **Child**

Influenza Vaccination Assessment & Consent Form

Provided by Visiting Nurse Association Home Support Services (VNA)

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS NOTIFY THE NURSE BEFORE IMMUNIZATION:

Y N
☐ ☐ Have you ever had a reaction to a flu shot?
☐ ☐ Are you allergic to eggs or egg products?
☐ ☐ Are you allergic to thimerosal (found in Visine or Murine eye drops)?
☐ ☐ Are you sick with a fever?
☐ ☐ Do you have an active nerve disorder like MS, Parkinson's disease, Lou Gehrig's disease?
☐ ☐ Do you have a history of Guillain-Barre' syndrome (a neurological disorder)?
☐ ☐ Have you received a vaccination for Hepatitis, Tetanus or Pneumonia in the past two weeks?
☐ ☐ Are you currently pregnant?

QUESTIONS

If you have any questions about the Influenza disease or the Influenza vaccination, **please ask the nurse for clarification now** or call your doctor before requesting the vaccine. **If you have any questions or concerns following vaccination, please call the Visiting Nurse Association at 248-967-8751. If you experience any adverse effects from the Influenza vaccination, please contact your physician and notify the Visiting Nurse Association (also notify your employer if you received your vaccination at work).**

CONSENT AND RELEASE FOR INFLUENZA VACCINE

- I have read this year 2010-2011 VIS regarding the influenza vaccination. I have had an opportunity to ask questions, and my questions have been answered to my satisfaction. I understand the benefits and risks of Influenza vaccination as described. I request that the vaccine be given to me. I understand the vaccination is being provided by Visiting Nurse Association Home Support Services (VNA). **I expressly release VNA from any liability resulting from the Influenza vaccine itself.**
- I agree to remain under observation for at least 15 minutes. Should I leave before that period lapses, I expressly release VNA from any liability resulting from any adverse reaction to the vaccine which may occur during that period and thereafter. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I understand side effects may include, but are not limited to: soreness at the injection site, fever, fatigue and headache. There is some risk for Guillain-Barre Syndrome. Severe reactions may include anaphylaxis and death.
- In the event a VNA employee is exposed to my blood or other body fluids, I agree to have my blood tested for HIV and Hepatitis and have the results released to VNA/exposed person but not to anyone else unless required/authorized by law.
- I acknowledge that I have received written information on VNA's "Notice of Privacy Practices" prior to the provision of service, and I have had the opportunity to have my questions answered.
- **I acknowledge that I am responsible to reimburse the VNA for charges not covered by my insurance _______.**
- **I agree to give a copy of this consent form to my employer (if applicable).**

PATIENT INFORMATION (please print)

________________________ ☐ Male ☐ Female ___/___/___ ______ ______
Name (Last, First, Middle) Birth Date **Age** Weight

____
Street Address / Apt. No. City/State Zip Code Telephone Number

________________________ ________________________
Medicare ID Number **or** Insurance ID & Group Number Responsible Party or Cardholder Information & Birth date

________________ ________________ ________________
Signature of Recipient/Date Email Address Payment & Volunteer Initial

TO BE COMPLETED BY THE NURSE OR CLERK

Clinic:________________

Diagnosis Code: **V04.81**
Procedure Codes: **90658** Vaccine
G0008 Administration

☐Yes ☐No I have received a flu shot in the past.
☐Yes ☐No **I have Medicare Part A (Hospital) & B (Medical) *and additional insurance.***
☐Yes ☐No **I am covered by Medicare Part A (Hospital) & B (Medical) only**.
☐Yes ☐No **I am covered by Medicare Part A (Medical) only.**
☐Yes ☐No I wish to have the Visiting Nurse Association bill Medicare/my insurance for the cost of my shot.

Dose 3 years and older:
0.5cc Trivalent A & B in ☐ right ☐ left deltoid, IM

Dose 6 months – 35 months:
0.25cc Trivalent A & B in ☐ right ☐ left thigh, IM

____
Lot No/Exp. Date

____
Signature of Nurse Giving Injection/Date