PMD__________
Immunet_______
PatTrac________
File Pro________
Billing__________

PNEUMONIA
VACCINE ADMINISTRATION RECORD

"I have read or have had explained to me the information in the Vaccine Information Statement(s) (VIS), or the important information statement(s) about the vaccine(s) listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) listed below, and ask that the vaccine(s) be given to me or to the person named below for whom I am authorized to make this request."

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)				
NAME: LAST	FIRST	M.I.		
STREET ADDRESS:	CITY	COUNTY	STATE	ZIP
DATE OF BIRTH	AGE	SEX ☐M or F☐	PHONE	
SOCIAL SECURITY # (Optional)	MARITAL STATUS:	RACE		

SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE REQUEST AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE (NPP) FORM:

X____ **DATE** ____________________

(If vaccine recipient is under 18 years of age, fill out the shaded section below)

Parent or Guardian Name: Last	**First**	**Middle Initial**	**Maiden**

FAMILY PHYSICIAN: ______________________________ADDRESS:____________________

In order for Medicare to pay for the vaccine, please complete the information below:

EXACT NAME ON MEDICARE CARD____

MEDICARE # ____

AUTHORIZATION SIGNATURE TO BILL____
IF INSURANCE DOES NOT PAY FOR VACCINE, PATIENT WILL BE RESPONSIBLE FOR PAYMENT.

FOR OFFICE USE ONLY

Form checked, insurance card seen (Name & Part B) VIS given and NPP witnessed by ______________ (Initials)

BILL MEDICARE PART B ONLY _________

PAID $_______ CASH ☐ CHECK ☐ # _______ RECEIPT #__________ CREDIT CARD ☐ CASHIER INITIALS ______

CC TYPE: Visa / MasterCard/Other CC#________________________ EXP DATE:_______ CC SECURITY#_______

Please turn page over and complete side 2 →

Name: ______________________________ DOB: ______________ Age: __________

<u>Please Circle *yes* or *no* to the following questions</u>:

	Question		
1.	Are you 19-64 years of age?	☐ *Yes*	*No* ☐
2.	Have you had a prior pneumonia vaccination?	☐ *Yes*	*No* ☐
3.	Has it been at least 5 years since your last pneumonia shot?	☐ *Yes*	*No* ☐
4.	Are you 65 years or older?	☐ *Yes*	*No* ☐
5.	Do you smoke?	☐ *Yes*	*No* ☐
6.	Do you have asthma, COPD, emphysema or other chronic lung diseases?	☐ *Yes*	*No* ☐
7.	Do you have diabetes?	☐ *Yes*	*No* ☐
8.	Do you have long-term heart, liver or kidney problems?	☐ *Yes*	*No* ☐
9.	Do you take long-term immune suppressive therapy (radiation, corticosteroids, etc	☐ *Yes*	*No* ☐
10.	Have you had an organ or bone marrow transplant?	☐ *Yes*	*No* ☐
11.	Have you ever had a reaction to ANY vaccine?	☐ *Yes*	*No* ☐
12.	Do you have a fever or other illness today?	☐ *Yes*	*No* ☐

********************FOR CLINIC/OFFICE USEONLY**********************		
Queen Anne's County Department of Health 206 N. Commerce Street Centreville, MD 21617		**Alternate site:**
Date of VIS or IIS:	**4/24/15**	
VACCINE GIVEN:	**Pneumococcal Polysaccaharide**	
DATE VACCINE ADMINISTERED:		
VACCINE MANUFACTURER:		
VACCINE LOT NUMBER & EXPIRATION DATE		
SITE OF INJECTION:	**Deltoid / Thigh** **R / L**	
SIGNATURE OF VACCINE ADMINISTRATOR:		

Revised 8/18/15