HomeHealth Visiting Nurses

HHVN USE ONLY
Clinic Name-Location
_____
☐ Cash/Check Check # _____
☐ Voucher _____
☐ Company Pay –Address_____
_____
CLERK'S INITIALS_____

FLU VACCINE CONSENT FORM

PRINT CLEARLY.

LAST NAME:	**FIRST NAME:**		**MIDDLE:**
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
BIRTH DATE: / **AGE:**	**☐ MALE ☐ FEMALE**	**PHONE #: ( )**	

_____CASH _____CHECK _____CREDIT CARD _____Insurance (see below)

(Circle your insurance)	**MEDICARE REPLACEMENT**	**MEDICARE B**	**ANTHEM**
Enter Insurance ID #			

ADVANTRA FREEDOM---AETNA MEDICARE---ANTHEM SMART VALUE---HARVARD FIRST SENIORITY---HUMANA---

MARTINS PT. GENERATIONS---SECURE HORIZONS---NORTHEAST COMM CARE---TODAYS OPTIONS

PLEASE			
SCREENING TOOL	YES	NO	
▪ **Have you ever had the influenza Vaccine before?** (If no, it is recommended that you stay in the area for about 15 minutes after receiving vaccine.)			☐ ☐
▪ Have you ever had a severe reaction to a previous influenza vaccine?			☐ ☐
▪ Are you allergic to eggs or chicken?			☐ ☐
▪ Do you have a past history of Guillain-Barre Syndrome?			☐ ☐
▪ Do you have a chronic disease?			☐ ☐
▪ Are you sick with a fever?			☐ ☐
▪ Do you take blood thinners?			☐ ☐
▪ Are you sensitive to Thimerosol?			☐ ☐

I have been provided a copy of the **Inactivated Influenza Vaccine Information Sheet** and had the opportunity to ask questions. I understand the benefits and risks of the influenza vaccine as described. I request that the vaccine be given to me or to the person named for whom I am authorized to sign. I acknowledge that no guarantees have been made concerning the results of the vaccine. I hold harmless, HomeHealth Visiting Nurses its employees, and the facility in which the vaccine was received. I request that payment of authorized benefits be made on my behalf directly to HomeHealth Visiting Nurses.
I AGREE TO PAY THE AMOUNT(S) NOT PAID OR IF MY CHARGES ARE DENIED FOR ANY REASON.
I hereby acknowledge my understanding of HomeHealth Visiting Nurses Notice of privacy Practices.

X _____ _____ _____
Patient or Authorized Representative | Reason patient is unable to sign | Date

STAFF USE ONLY BELOW THIS LINE

VACCINE: Fluzone EXPIRES: 6/30/09 NURSE'S SIGNATURE: _____ DATE: / /08
Lot # U 2751AA_____ Dose: 0.5 ml DELTOID INJECTION SITE: L / R ARM