SHARP Rees-Stealy Medical Centers

ADULT (18 years and older) INFLUENZA VACCINE ADMINISTRATION FORM 2020-2021

Patients Name: ___________________________________

Date of Birth: ___________________________________

Primary Physician: ________________________________

MRN or Employee/Physician #:__ _____________________

(Or place patients label here)

FOR PATIENTS:

Please answer following questions:

1. Have you received the flu vaccine in the last 6 months? ☐ YES ☐ NO ☐ NOT SURE
2. Have you been ill in the last 24 hours? ☐ YES ☐ NO
3. Are you allergic to Neomycin/Gentamicin? ☐ YES ☐ NO
4. Do you have a history of Guillian Barre? ☐ YES ☐ NO
5. Have you ever had a previous influenza vaccine reaction? ☐ YES ☐ NO

_________________________________ _____________________________

Patient Signature Date

For Employees: I give consent to have this documented in my SRS medical record. ☐ YES ☐ NO

FOR CLINICAL STAFF ONLY:

Refer to standing order and influenza formulation grid

Influenza vaccine 0.5 ml. IM Site given: ☐ Right Deltoid ☐ Left Deltoid

Lot #: ____________ Manufacturer: _____________________ Expiration date: __________

2 patient identifiers verified________ Patient's temperature (if indicated): __________________

No signs of adverse reaction noted ☐

____ _____________________________

Clinical Staff's Signature & Title Date

_____________________________________ _____________________________

Ordering Physician's Signature (if required) Date

MD Verified Medication ☐

CDC Vaccine Information Sheet Given:

English ☐ Spanish ☐ Other ☐ Date: _________

CPT CODE	ADMIN CODES	CHECK ONE
90686X Fluarix 6 mos+	G0008	
90674C Flucelvax Cell Cultured Derived 4+ yrs	G0008	
90686V Flulaval 6 mos +	G0008	
90686Z Fluzone 6 mos+	G0008	
90694D Fluad 65yrs +	G0008	

Staff Use Only: Immunization history entered in EHR ☐ **Charges entered in EHR** ☐