SAMPLE INFLUENZA/PNEUMOCOCCAL VACCINE

Patient Assessment and Vaccine Order/Administration Form

Based on combined influenza and pneumococcal program
and a requirement for an individual physician order prior to immunization.

Effective Annually: October 1 through January 31 for Influenza Vaccine, Year-round for Pneumococcal Vaccine

I. PATIENT ASSESSMENT.
Assessed by: __________________________ Date: __________________

RISK ASSESSMENT. Patient is at “high-risk” due to: (check all that apply)
☐ Age 65 or older
☐ Age less than 65 and history of heart disease, lung disease, weakened immune system, diabetes, or other chronic condition.
☐ None of the above listed.

STOP: PATIENT IS NOT AT HIGH RISK. NO FURTHER ASSESSMENT NEEDED.

CONTRAINDICATIONS. Vaccine NOT Indicated due to: (check all that apply)

INFLUENZA
☐ Previously immunized this “flu season”
☐ Allergic to eggs or thimerosal (preservative in contact lens solution)
☐ Previous reaction to influenza vaccine
☐ Physician order not to give vaccine this hospitalization

PNEUMOCOCCAL
☐ Previously received pneumococcal vaccine (recommended 1 x dose after age 65)
☐ Previous reaction to pneumococcal vaccine
☐ Physician order not to give vaccine this hospitalization

STOP: IF VACCINE CONTRAINDICATED, NO FURTHER ASSESSMENT NEEDED.

VACCINE INDICATED and NOT ADMINISTERED.

PATIENT REFUSAL (Check reason that applies)

FLU VACCINE
If patient responds “don’t know”/”don’t want,” pursue reason
☐ Believes not at risk for disease.
☐ Believes vaccine won’t work.
☐ Fear of adverse effects.
☐ Wants further advise (e.g. physician, family)
☐ Would rather receive elsewhere.
☐ Other: Document specific refusal reason given by patient: __________________________

PNEUMOCOCCAL VACCINE
If patient responds “don’t know”/”don’t want,” pursue reason
☐ Believes not at risk for disease.
☐ Believes vaccine won’t work.
☐ Fear of adverse effects.
☐ Wants further advise (e.g. physician, family)
☐ Would rather receive elsewhere.
☐ Other: Document specific refusal reason given by patient: __________________________

OTHER REASON VACCINE NOT ADMINISTERED

Specify: _______________________________________________________________________

Patient plan for influenza immunization is: __________________________
_____________________________________________________________________________
_____________________________________________________________________________

Patient plan for pneumococcal immunization is: __________________________
_____________________________________________________________________________
_____________________________________________________________________________

FLU VACCINE ADMINISTERED
Date: _____/_____/_____ Time: ________
Site: __________________________
By: __________________________
Manufacturer: (if applicable) _____________
Lot Number: _________________________

PNEUMOCOCCAL VACCINE ADMINISTERED
Date: _____/_____/_____ Time: ________
Site: __________________________
By: __________________________
Manufacturer: (if applicable) _____________
Lot Number: _________________________

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