

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.”

<b>INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)</b>				
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)				
<b>Parent or Guardian Name:</b> 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.

<b>FOR OFFICE USE ONLY</b>	
Form checked, insurance card seen (Name & Part B) VIS given and NPP witnessed by _____ (Initials)	
BILL MEDICARE PART B ONLY _____	
PAID \$ _____ CASH <input type="checkbox"/> CHECK <input type="checkbox"/> # _____ RECEIPT # _____ CREDIT CARD <input type="checkbox"/>	CASHIER INITIALS _____
CC TYPE: Visa / MasterCard/Other CC# _____ EXP DATE: _____ CC SECURITY# _____	

Please turn page over and complete side 2

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

**Please Circle yes or no to the following questions:**

- |  |     |    |
|--|-----|----|
| 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 |

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