Madelia
Community
Hospital & Clinic

Influenza Vaccination 2017/2018

Name: ____

DOB: ____

Billing Preference **(Please check one)**

___ I wish to receive my flu vaccine through the "Direct Access" program. I do not wish to have my insurance billed for the flu vaccine. (Medicare Patients not eligible) I will pay the cost of:

$40 $65 for High Dose Vaccine (Recommended for patients 65 & older)

Method of Payment: ☐**Cash** ☐ **Check** ☐ **Credit Card**

___ Please bill my insurance company for the cost of my flu vaccine and the administration fee.

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.	**YES**	**NO**	**Don't Know**
1. Is the person to be vaccinated sick today? Fever of 100.5 or higher.			
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?			
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?			
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?			

Form completed by: ____ Date:_______________

Form reviewed by: ____ Date:_______________

Site: Left Deltoid
Right Deltoid
Left Thigh Other:
Right Thigh

Place vaccine label here:

MNVFC (18 yrs and younger) YES NO

Provider visit at time of vaccine: YES NO

Entered in Allscripts or MIIC________

Billing codes:
Admin—**G0008-Medicare**
Admin—**90471-Other**
Dx—**Z23**

Nurse signature:_________________________________ Date:_____________________