**RICHLAND COUNTY TB & HEALTH OFFICE**

**ADULT FLU SCREENING FORM**

|  |  |  |
| --- | --- | --- |
|  | **NO** | **YES** |
| **1. Is the person to be vaccinated sick or have a fever today?** |  |  |
| **2. Does the person to be vaccinated have an allergy to eggs or any other allergy? List allergy:** |  |  |
| **3. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?** |  |  |
| **4. Has the person to be vaccinated ever had Guillain-Barre syndrome (a disease causing temporary paralysis)?** |  |  |
| **5. I have received the vaccine information sheet, had a chance to ask questions regarding the vaccine and understand the risks and benefits of the vaccine.**  |  |  |

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|  Patient's Age: \_\_\_\_\_\_\_\_\_\_ Patient's Dr. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **ETHNICITY:** Hispanic or Latino Not Hispanic or Latino Unknown |
| **RACE:** American Indian or Alaska Native Black or African-American Hispanic or Latino  Asian Native Hawaiian or Other Pacific Islander Other race White Unknown |
| **Insurance:** Medicare Medicaid Insurance No Insurance |

Date of Service:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: (Circle One) M or F

I authorize Richland County Health Office for immunizations given and to release service related information regarding the above mentioned person to third party payors and/or other health practitioners and to bill for service rendered to me if applicable. I request my payor to pay RCHO directly for services rendered to me.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Check one** | **Vaccine Lot #** **& Expiration Date** | **Vaccine Name/Mfg/Description** |
|  |  UT7701KA Exp. 6/30/23  | Sanofi Fluzone (IIV4) syringe (6 mo and up) |
|  |  Exp.  | Sanofi Fluzone (IIV4) syringe (6 mo and up) |
|  |  UJ891AA Exp. 6/14/23 | Sanofi Flublok (IIV4) syringe (18 yrs and up) |
|  |  Exp.  | Sanofi Flublok (IIV 4) syringe (18 yrs and up) |
|  |  Exp.  | Sanofi Flublok (IIV 4) syringe (18 yrs and up) |
|  | UT7714CA Exp. 6/30/23  | Sanofi Fluzone HD (IIV4) >65 yr |
|  | UT7743AA Exp. 6/30/23  | Sanofi Fluzone HD (IIV4) >65 yr |
|  |  |  |
|  |  |  |

Insurance Type: □ Insurance □ Medicare □ Medicaid □ Self Pay

|  |  |  |  |  |  |  |  |  |  |  |
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| **√** | **Flu Vaccinations** | **DX** | **CPT** | **Fee** |  | **√** | **Nursing Services** | **DX** | **CPT** | **Fee** |
|  | Fluzone Syringe (6mo & up) | Z23 | 90688 | $30 |  |  | Brief Office Visit | Z23 | 99211 | $30 |
|  | Flublok | Z23 | 90682 | $70 |  |  | Adult Administration | Z23 | 90471 | $30 |
|  | HD Fluzone >65 yrs | Z23 | 90662 | $70 |  |  | Flu Administration – Medicare | Z23 | G0008 | $25 |
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|  |  |  |  |  |  |  |  Total charges for service $ |
|  |  |  |  |  |  |  |  Balance Due $ |
|  |  |  |  |  |  |  | [ ] Cash [ ] Credit/ Debit [ ] Check # |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | Nurse: |  |
|  |  |  |  |  |  |  |  |  |  |  |

Update 9/28/2022