Catawba County Public Health - Influenza/Pneumococcal Vaccines (2013-2014 Season)

The doctor or clinic may keep this record in your medical file or your child's medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the signature and title of the person who gave the vaccine, and the location where the vaccine was given.

I have read or have had explained to me the information on this form about influenza/pneumococcal disease and the influenza/pneumococcal vaccine(s). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza/pneumococcal vaccine(s) 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. I confirm that I have had an opportunity to review Catawba County Public Health's Notice of Privacy Practices.

I authorize payment of government/insurance benefits to Catawba County Public Health and I authorize Catawba County to share any information necessary to facility payment for this service.

Can we call you? ☐ Yes ☐ No **Can we write to you? ☐ Yes ☐ No**

Signature: _____ Date: ___-___-_____ Printed Name: _____
(printed name only if different than client's name)

Client ID: _____ Client SS#: _____-____-_____ CNDS ID#_____

Date of Birth: ___-___-_____ Telephone: (_____)_____-_____ SSI Income? (< 18 only) ☐ Yes ☐ No

Client Name: _____ Sex: ☐ Male ☐ Female

Client Address: _____ County: _____

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Unknown
Hispanic? ☐ Yes ☐ No

Preferred Language: ☐ Spanish ☐ Hmong ☐ Chinese ☐ Arabic ☐ Cambodian ☐ English
☐ French ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other

Fund Source(s): ☐ Self-Pay (6)
☐ Medicare (CMS Part B only)(S-2) - ID# _____ (must end with a letter)
☐ NC Medicaid (R-1) - ID# _____ Effective Date: ___-___-_____
☐ NC Health Choice (R-NCHC) - ID# _____ Effective Date: ___-___-_____
☐ Commercial Insurance or Medicare Advantage Plan (5) - ID# _____
Effective Date: ___-___-_____ Group ID: _____ Telephone (____)_____
☐ Employer/Group (Z) - Name of Employer/Group: _____

Form Completion

NCIR Entry

Insight Registration

		Vaccine furnished by State of NC						Paid vaccines		
		Influenza ICD-9 V04.81						Influenza ICD-9 V04.81		Pneumococcal ICD-9 V03.82
		.25ml PF prefilled syringe	.5ml PF prefilled syringe	Quadrivalent .5ml PF syringe (36m-18yr)	.25ml injection (6month - 35 months)	.5ml Injection (3+ years)	Quadrivalent for intranasal use	Fluzone REG-Dose **$20.00**	Fluzone HIGH-Dose **$38.00**	**$70.00**
Vaccine Code		90655-ST	90656-ST	90686-ST	90657-ST	90658-ST	90672-ST	90658	90662	90732
Vaccine Admin	Medicare/ Med Advt	G0008	G0008	G0008	G0008	G0008	G0008	G0008	G0008	G0009
	1st vaccine	90471-ST	90471-ST	90471-ST	90471-ST	90471-ST	90473-ST	90471	90471	90471
	Addt'l vaccine	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	90472

Administering Staff ID & Initials:	
Date Vaccine Administered:	
Vaccine Manufacturer & Lot Number:	
Date of Important Information Sheet:	
Site of Injection:	