| Page 1 of 1 | **Dialysis Patient Influenza Vaccination** | | | | | | | | | | | | | | | | | | | | | \* required for saving  ^ conditionally required |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| \*Facility ID: | | | | | | | | | | | | \*Event #: | | | | | | | | | | |
| \*Patient ID: | | | | | | | | | | | | Social Security #: | | | | | | | | | | |
| Secondary ID: | | | | | | | | | | | | Medicare #: | | | | | | | | | | |
| Patient Name, Last: First: Middle: | | | | | | | | | | | | | | | | | | | | | | |
| \*Gender: M F Other | | | | | | | | | | | | \*Date of Birth: | | | | | | | | | | |
| Ethnicity (specify): | | | | | | | | | | | | Race (specify): | | | | | | | | | | |
| \*Event Type: FLUVAXDP | | | \*Influenza subtype: | | | | | **□** Seasonal | | | | **□** Non-Seasonal | | | | | | \*Event Date: | | | | |
| \*Patient Dialysis Modality: | | | | **□** In-center hemodialysis | | | | | | | | **□** Home hemodialysis | | | | | | | | **□** Peritoneal dialysis | | |
| \*Was vaccine administered (select one): | | | | | | | | | | | | | | | | | | | | | | |
| **□** Onsite – patient vaccinated in this facility *(complete “Facility Vaccination Administration Information” section)* | | | | | | | | | | | | | | | | | | | | | | |
| **□** Offsite – patient previously vaccinated elsewhere for this flu season | | | | | | | | | | | | | | | | | | | | | | |
| **□** Declined – patient declined vaccine *(complete “Reason(s) Vaccine Declined” section)* | | | | | | | | | | | | | | | | | | | | | | |
| **Reason(s) Vaccine Declined (complete either section A or B, but not both)** | | | | | | | | | | | | | | | | | | | | | | |
| ^A. Medical contraindication(s) (check all that apply): | | | | | | | | | | | ^B. Personal reason(s) for declining (check all that apply): | | | | | | | | | | | |
| **□** Allergy to vaccine components | | | | | | | | | | | **□** Fear of needles/injections | | | | | | | | | | | |
| **□** History of Guillain-Barré syndrome within 6 weeks of previous influenza vaccination | | | | | | | | | | | **□** Fear of side effects | | | | | | | | | | | |
| **□** Perceived ineffectiveness of vaccine | | | | | | | | | | | |
| **□** Current febrile illness (temp > 101.5°F in past 24 hours) | | | | | | | | | | | **□** Religious or philosophical objections | | | | | | | | | | | |
| **□** Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | **□** Concern for transmitting vaccine virus to contacts | | | | | | | | | | | |
|  | | | | | | | | | | | **□** Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| **Facility Vaccination Administration Information:** | | | | | | | | | | | | | | | | | | | | | | |
| Type of influenza vaccine administered: | | | | | | | | | |  | | | | | | | | | | | | |
| ^Seasonal: | | **□** Afluria® | | | | | **□** Agriflu® | | | **□** Fluarix® | | | | | | | **□** FluLaval® | | | | | |
|  | | **□** Fluvirin® | | | | | **□** Fluzone® | | | **□** Fluzone High-Dose® | | | | | | | **□** Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| ^Non-seasonal: | | **□** Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | |
| ^Type of vaccine: | | | | | **□** Inactivated influenza vaccine (TIV) | | | | | | | | |  | | | | | | | | |
| Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | Lot number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| ^Route of administration: | | | | | **□** Intramuscular | | | | | **□** Intranasal | | | | | | **□** Subcutaneous | | | | | | |
| Vaccine Information Statement (VIS) provided to patient: | | | | | | | | | | **□** Yes | | | **□** No | **□** Unknown | | | | | Edition Date: | | | |
| Person Administering Vaccine: | | | | | | | | | | | | | | | | | | | | | | |
| Vaccinator ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| Name: Last: | | | | | | | | | First: | | | | | | Middle: | | | | | | | |
| **Custom Fields** | | | | | | | | | | | | | | | | | | | | | | |
| Label | | | | | | Data | | | | | Label | | | | | | | | | | Data | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Comments** | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
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