| 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 |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **Comments** |
|  |
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