Visiting Nurse Association **Date:** _____ **Location:** _____ ADULT

1524 Sycamore Street
Iowa City, IA 52240 Phone: 319-337-9686

VIS: Flu Shot-(IIV)-8/7/15 Pneumonia-(PPSV23)-4/24/15 Pneumonia-(PCV13)-11/5/15

Patient Information (Please Print)

Last Name:_____ **First:**_____ **Gender: M / F**

Address: _____ **City:**_____ **State:**____ **Zip Code:**_____

Phone:_____ **Birthdate:**_____ **Age:**_____

Social Security:_____ **Physician:**_____
(NA if self/contract pay)

Patient Consent

Special Cautions (See Vaccine Information Sheet for details)

1. If you have any of the following, obtain vaccination under your doctor's supervision
   * Have had a serious allergic reaction to eggs or a vaccine component, including Thimerosal
   *Have had previous severe reaction to flu/pneumonia shots
   *Have an active neurological disorder (delay until stabilized) or history of Guillain-Barre Syndrome
2. If you have an acute infection with fever over 100 F, delay immunization until you are recovered.
3. **High Dose Influenza vaccine is for individuals, aged 65 years and older to help boost immune response.**

I have read the information sheet about the influenza/pneumonia vaccine. The information I have provided above is correct and true to my knowledge. I understand the benefits and risks of the vaccination and request that the vaccine be given to me or to the person listed above, for whom I am authorized to make this request. **If insurance denies payment, or my original method of payment is rejected, I agree to be personally responsible for full payment**. I understand all information obtained by the VNA will be used only for treatment, payment, or health operations.

_____ _____
Signature of person to receive vaccine or authorized to sign Date

Please initial I authorize:
_____Influenza Regular Injection
_____Influenza High Dose Injection (age 65+)
_____ Pneumonia Injection

Flu: $38 ($35 cash/check now) High-dose Flu: $65 ($62 cash/check now) Pneumonia: PPSV23 $132 or PCV13 $185

Payment Information (Please show insurance card to receptionist)

❑**Medicare B:** Medicare #_____

❑**MC Replacement:** Plan Name_____ Policy #_____ Phone_____

❑ **Primary Insurance Carrier:** _____Claims Address**:** _____Phone_____

Policy # / Member ID_____ Group # / Employer_____

Policy Holder:_____ Patient relationship to policy holder: ❑Self ❑Spouse ❑Child ❑Other

❑**Patient Pay Full:** Amount $_____ ❑cash ❑check #_____

❑**Voucher Payment:** Voucher #_____

❑**Company Pay Full** Company Name_____

To be completed by VNA Nurse

❑**Flu Vaccine IM:** ❑L Deltoid ❑R Deltoid ❑Other _____ **Lot Number**_____
Dose: ❑0.5 cc Regular ❑0.5 cc Pres Free

❑**High-dose Flu Vaccine, 0.5 cc, IM**: ❑L Deltoid ❑R Deltoid ❑Other _____**Lot Number**_____

❑**Pneumonia Vaccine, 0.5 cc, IM**: ❑L Deltoid ❑R Deltoid ❑Other _____**Lot Number**_____

***Nurse Signature**_____