OMB No. xxxx-xxxx
Exp. Date: xx-xx-20xx

High Risk Inpatient Influenza Vaccination Monthly Monitoring Form – Method B

* required for saving

Record the number of patients for each category below for the month being reviewed.

*Facility ID# :		
*Vaccination type: Influenza	*Month:	*Year:

Patient categories	**Number of patients in each category**
*1. Total # of patient admissions	
2. Total # of patients previously vaccinated during current influenza season	
*3. Total # of patients meeting high risk criteria previously vaccinated during current influenza season	

Optional fields:

Label _____ _____ _____ _____ _____

Data _____ _____ _____ _____ _____