



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:	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Non-Seasonal
		*Event Date:	
*Patient Dialysis Modality:	<input type="checkbox"/> In-center hemodialysis	<input type="checkbox"/> Home hemodialysis	<input type="checkbox"/> 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)

<p>^A. Medical contraindication(s) (check all that apply):</p> <p><input type="checkbox"/> Allergy to vaccine components</p> <p><input type="checkbox"/> History of Guillain-Barré syndrome within 6 weeks of previous influenza vaccination</p> <p><input type="checkbox"/> Current febrile illness (temp > 101.5°F in past 24 hours)</p> <p><input type="checkbox"/> Other (specify): _____</p>	<p>^B. Personal reason(s) for declining (check all that apply):</p> <p><input type="checkbox"/> Fear of needles/injections</p> <p><input type="checkbox"/> Fear of side effects</p> <p><input type="checkbox"/> Perceived ineffectiveness of vaccine</p> <p><input type="checkbox"/> Religious or philosophical objections</p> <p><input type="checkbox"/> Concern for transmitting vaccine virus to contacts</p> <p><input type="checkbox"/> Other (specify): _____</p>
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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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 CDC 57.505 rev 2, v 8.3