

APPENDIX 5A.1: PROVIDER PEDIATRIC VACCINATION HISTORY REQUEST LETTER/FORM

Date: [current date]

Dear Dr. [LastName]:

The [State/Local Health Department], in collaboration with the Centers for Disease Control and Prevention, are tracking patients who have been hospitalized with influenza. A patient from your clinic, **Patient Name (DOB: MM/DD/YYYY)**, was reported to us as having been hospitalized with influenza beginning on **MM-DD-YYYY**. We are trying to obtain immunization history on all hospitalized patients and would appreciate your help in completing the information below for this patient. **If this was not a patient seen by you or another provider at your clinic, please mark “Unknown” for question 1 or 2 below.**

Please fax the completed form to **XXX-XXX-XXXX**. For any questions, please contact <PI/SO>, at **XXX-XXX-XXXX**. Thank you in advance for your help.

Investigation of these cases falls within the scope of public health surveillance. The Health Insurance Portability and Accountability Act (HIPAA) does NOT prohibit your reporting this information to public health authorities (see <http://aspe.hhs.gov/admsimp/PL104191.htm>, Section 1178 (b)).

FOR CHILDREN

1. Did the patient receive influenza vaccine during fall or winter of the current influenza season? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
1a. Indicate the number of doses: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Unknown
1b. For each dose, specify the date given (mm-dd-yyyy): Dose 1: ____ / ____ / ____ Dose 2: ____ / ____ / ____
1c. If patient < 9 years old, specify vaccine type: <input type="checkbox"/> Injected Vaccine <input type="checkbox"/> Nasal Spray/FluMist <input type="checkbox"/> Combination of both <input type="checkbox"/> Unknown Type
2. If patient < 9 years old, did d the patient receive influenza vaccine in any previous seasons? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<i>To help us complete medical information about your patient, could you please provide us with their height and weight if this information was obtained within 6 months before their hospitalization?</i>
3. HEIGHT: _____ <input type="checkbox"/> inches <input type="checkbox"/> centimeters 4. WEIGHT: _____ <input type="checkbox"/> pounds <input type="checkbox"/> kilograms
<i>To help us complete the demographic information about your patient, could you please provide us with their race and ethnicity?</i>
5. Race (check only one): <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Multiracial <input type="checkbox"/> Not specified
6. Ethnicity (check one): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Not Specified

