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/admnsimp/PL104191.htm, Section 1178 (b)).

FOR CHILDREN

1. Did the patient receive influenza vaccine during fall or winter of the current influenza season?
☐ Yes ☐ No ☐ Unknown

1a. Indicate the number of doses: ☐ 1 ☐ 2 ☐ 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:
☐ Injected Vaccine ☐ Nasal Spray/FluMist ☐ Combination of both ☐ Unknown Type

2. If patient < 9 years old, did d the patient receive influenza vaccine in any previous seasons?
☐Yes ☐ No ☐ Unknown

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?

3. HEIGHT: _____ ☐ inches ☐ centimeters **4. WEIGHT:** _____ ☐ pounds ☐ kilograms

To help us complete the demographic information about your patient, could you please provide us with their race and ethnicity?

5. Race *(check only one):* ☐ White ☐ Black or African American ☐ Asian/Pacific Islander
☐ American Indian/ Alaska Native ☐ Multiracial ☐ Not specified

6. Ethnicity *(check one):* ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Not Specified

APPENDIX 5A.2: PROVIDER ADULT 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 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/admnsimp/PL104191.htm, Section 1178 (b)).

FOR ADULTS

1. Did the patient receive influenza vaccine during fall or winter of the current influenza season?
☐ Yes ☐ No ☐ Unknown

1a. If yes, specify the date given (mm-dd-yyyy): _____ /_____ /_____

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?

2. HEIGHT: _____ ☐ inches ☐ centimeters **3. WEIGHT:** _____ ☐ pounds ☐ kilograms

To help us complete the demographic information about your patient, could you please provide us with their race and ethnicity?

5. Race *(check only one):* ☐ White ☐ Black or African American ☐ Asian/Pacific Islander ☐ American Indian/ Alaska Native ☐ Multiracial ☐ Not specified

6. Ethnicity *(check one):* ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Not Specified