



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:	☐ Seasonal	☐ Non-Seasonal	*Event Date:	
*Patient Dialysis Modality:		☐ In-center hemodialysis	☐ Home hemodialysis	☐ 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)					
^A. Medical contraindication(s) (check all that apply): ☐ Allergy to vaccine components ☐ History of Guillain-Barré syndrome within 6 weeks of previous influenza vaccination ☐ Current febrile illness (temp > 101.5°F in past 24 hours) ☐ Other (specify): _____			^B. Personal reason(s) for declining (check all that apply): ☐ Fear of needles/injections ☐ Fear of side effects ☐ Perceived ineffectiveness of vaccine ☐ Religious or philosophical objections ☐ Concern for transmitting vaccine virus to contacts ☐ Other (specify): _____		
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	
_____		_____		_____	
_____		_____		_____	
_____		_____		_____	
Comments					
Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).					
Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666). CDC 57.505 rev 2, v 8.3					