Form Approved
OMB No. 0920-0666
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# 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 | Data |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**Comments**