



# 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 &gt; 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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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