

McLaren Print System Order

Order No: 49832 Reprint Previous Order No: 5506
Order Date: 2019-10-30
User: Danielle Sowers
Phone: 586-226-3500

Ship Location: McLaren Macomb Internal Medicine & Health
37399 Garfield, Suite 106
Clinton Township, MI 48036

Forms

Quantity: 100
Paragon Dept No: 71650
Dept Name: McLaren Macomb Internal Medicine & Health
Company Number: 810

Order Total Price: 23.40

Item Number: MM-474
Item Description: Influenza Consent Form
Revision Date: 8/2019
Print: 1 sided black and white
Paper: 2 Part (White, Yellow)
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info: This form must be ordered with DCH-0457

McLaren MEDICAL GROUP INFLUENZA CONSENT & ADMINISTRATION FORM
Last Name, First Name, Sex, Q/Male Q/Female
Address, Date of Birth
City, State, Zip
Telephone, Primary Care Provider (PCP)
1. Do you have any severe, life-threatening allergies?
2. Have you ever had a severe reaction to a previous influenza vaccine or any of its components?
3. Do you have a fever or acute illness?
4. Do you have a history of Guillain-Barre Syndrome?
5. Do you have a history of asthma or wheezing?
Signature of Patient or Authorized Representative, Date
FOR MEDICARE PATIENTS ONLY
I request that this provider be paid authorized Medicare benefits on my behalf for any services furnished to me. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine those benefits for related services. I understand that I am responsible for the charges if my Medicare coverage is not appropriate.
Site of Injection: Q/Right Deltoid Q/Left Deltoid Q/Right Anterolateral Thigh Q/Left Anterolateral Thigh Q/Intranasal
Lot Number, Manufacturer, Expiration Date
Administered by, Date, Time