

McLaren Print System Order

Order No: 5793
Order Date: 2014-09-15
User: Dawn McPherson
Phone: 586-226-3500

Ship Location: McLaren Macomb Int. Med. Health / Dawn McPherson
37399 Garfield - Suite 106
Clinton Township, Mi 48036

Forms

Quantity: 500
Paragon Dept No: 71650
Dept Name: MMG - McLaren Macomb Internal Medicine and Health
Company Number: 810

Order Total Price: 29.75

Form Number: MM-474 (71650)
Form Description: Influenza Consent Form (McLaren Macomb Internal Med.)
Revision Date: 8/2014
Print: 1 sided black and white
Paper: 2 Part (White, Yellow)
Size: 8.5 x 11
Fold:
Finish:
Drill: None

McLaren Medical Group
INFLUENZA CONSENT FORM
Last Name, First Name, Sex, Address, City, State, Zip, Telephone, Primary Care Provider (PCP)
Not all individuals regarding the flu vaccine can safely be immunized against influenza. Please complete the following questions to evaluate any contraindications.
For any YES responses, if active patient at this site, review with the provider. Otherwise, refer the patient back to their PCP.
I have reviewed and authorize vaccine administration. Provider Signature, Date, Time
1. Have you ever had a severe reaction to a previous influenza vaccine?
2. Are you allergic to eggs, chicken feathers, chicken or chicken tenderloin?
3. Are you allergic to Thimerosal (a mercury derivative found in contact lens solution and Merthiolate)?
4. Are you allergic to latex?
5. Do you have a fever or active illness?
6. Are you pregnant?
7. Do you have a past history of Guillain-Barre Syndrome?
8. Have you received another type of vaccine in the past fourteen (14) days?
9. Are you under the age of eighteen (18)?
10. Are you currently receiving blood thinners such as coumadin, aspirin or heparin?
I have read the above information and have had the opportunity to ask questions. I understand the benefits and risks of the influenza vaccine as described. I request the flu vaccine to be given to me or to the person named for whom I am authorized to sign.
Signature Patient or Authorized Representative (Relationship), 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. Medicare Number
Patient Signature, Payment to Patient, Payment to Provider
We were unable to administer your influenza vaccine today due to a contraindication. Please take a copy of this form to your primary care provider.
Site of Injection, Lot #, Manufacturer, Expiration Date
Given by, Date, Time
INFLUENZA CONSENT FORM