

McLaren Print System Order

Order No: 6684
 Order Date: 2014-10-23
 User: Danielle Sowers
 Phone: 586-791-7630

Ship Location: McLaren Family Medicine/Danielle Sowers
 35103 Silvano Drive
 Clinton Township, MI 48035

Forms

Quantity: 500
 Paragon Dept No: 71000
 Dept Name: McLaren Family Medicine/Silvan
 Company Number: 810

Order Total Price: 58.50

Item Number: MM-474
 Item Description: Influenza Consent Form
 Revision Date:
 Print: 1 sided black and white
 Paper: 2 Part (White, Yellow)
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill: None
 Misc Info: Vaccine Information Statements are ordered separately.

McLaren Medical Group
INFLUENZA CONSENT FORM

Last Name _____ First Name _____ Sex: Male Female

Address _____ Date of Birth: _____

City _____ State _____ Zip _____

Telephone: (____) _____ Primary Care Provider (PCP) _____

Not all individuals responding to the flu vaccine can safely be immunized against influenza. Please complete the following questions to evaluate any contraindications:

For any YES response, 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you allergic to eggs, chicken feathers, chicken or chicken tender?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you allergic to Thimerosal (a mercury derivative found in certain lens solution and Merthiolate)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you allergic to latex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you have a fever or swollen throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you have a past history of Guillain Barre Syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you received another type of vaccine in the past fourteen (14) days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Are you under the age of eighteen (18)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Are you currently receiving blood thinners such as coumadin, aspirin or heparin?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Influenza vaccine is composed of dead influenza viruses and will not give you the flu. It is given by injection. As with any medication, there are risks and possible side effects/reactions. Side effects of influenza vaccine are generally mild and subside about 30 minutes after vaccination and are limited to one or two days. These reactions consist of soreness at the injection site, fever, chills, muscle aches and/or sore throat. If you should have a reaction, CONTACT YOUR PHYSICIAN IMMEDIATELY.

Having received influenza vaccine information (dated 8/18/10) and informed consent, I hereby agree to release and hold McLaren Medical Group, its employees, agents and representatives harmless from further responsibility with regard to my receiving the vaccine.

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 these 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: Right Deltoid Left Deltoid Right Anterolateral Thigh Left Anterolateral Thigh

Lot # _____ Manufacturer _____ Expiration Date _____

Given by _____ Date _____ Time _____

INFLUENZA CONSENT FORM
ORIGINAL - Center COUNTY - Patient