I. INFLUENZA VACCINE (Administered yearly). Has the Patient been immunized in this flu season?

☐ YES  ☐ NO  IF YES, PROCEED TO STEP II

RISK ASSESSMENT - Patient is eligible for vaccination(s) if patient meets at least one of the following criteria:

☐ Any adult who wants to reduce their chance of getting influenza

CONTRAINDICATIONS FOR INFLUENZA VACCINE

Vaccine NOT indicated due to (check box that applies):

☐ Allergy to eggs or to any component(s) of the vaccine, e.g., Thimerosal-contact lens solution

☐ Time frame - April 1 through September 30

☐ Patients who have developed Guillain-Barre syndrome within 6 weeks of a previous influenza vaccination

Pregnancy itself is not a contraindication.

If vaccine contraindicated, check “NO” under immunization order, date and sign. Proceed to Part II.

II. PNEUMOCOCCAL VACCINE Has the Patient been immunized within the past 5-years?

☐ YES  ☐ NO  IF YES, PROCEED TO STEP V

RISK ASSESSMENT - Patient is eligible for vaccination if patient meets at least one of the following criteria:

☐ Age 65 or older

☐ Residents of nursing homes and/or chronic care facility

☐ Anyone with a chronic health problem-Chronic illness-heart, lung, liver, kidney disease, alcoholism, diabetes, chronic CSF leak, sickle cell anemia, absent/damaged spleen

☐ Anyone who is immunocompromised

☐ Including leukemia, lymphoma, Hodgkins disease, multiple myeloma, generalized malignancy. (If chemotherapy or radiation is being considered, give vaccine at least 14 days before treatment.)

☐ Long-term systemic corticosteroids

☐ Transplant recipient

☐ Persons who are HIV+ and/or have AIDS

☐ Revaccination with pneumococcal vaccine recommended every five years for persons with the following conditions: nephrotic syndrome, renal failure, transplant recipients, spleen removal, damaged spleen, sickle cell disease, HIV or AIDS

☐ None of the above, STOP, patient NOT eligible. DO NOT ADMINISTER VACCINE, check “NO” under immunization order, date and sign.

CONTRAINDICATIONS FOR PNEUMOCOCCAL VACCINE

Vaccine NOT indicated due to (check box that applies):

☐ Previous adverse reaction

☐ Bone Marrow Transplant within 12 month

☐ Currently receiving chemo/radiation therapy

III. PATIENT REFUSED INDICATE REASON

☐ Influenza  ☐ Pneumococcal

☑ Patient refused vaccine(s) refused by patient

☐ Believes not at risk for disease

☐ Believes vaccine won’t work

☐ Fear of adverse effects, explain: ______________________________________________________________________

☐ Other: Document specific reason:_____________________________________________________________________

IV. IF IMMUNIZATION STATUS IS UNKNOWN AND/OR THE PATIENT IS CONFUSED, VACCINATION SHOULD BE GIVEN IF INDICATED.

V. IMMUNIZATION ORDER (Check) Administer the following vaccines:

☐ YES  ☐ NO  GIVE FLU VACCINE (0.5 ml IM IN DELTOID)

☐ YES  ☐ NO  GIVE PNEUMOCOCCAL VACCINE (0.5 ml IM IN DELTOID)

IF YES, administer vaccines per hospital protocol.

Nurse completing:______________________________________________________ Date/Time:_____________________________

Transcriber’s Signature: _________________________________________________ Date/Time:_____________________________