**Which Vaccines Do I Need Today?**

**Hepatitis A vaccine** (check all that apply)

* I want to be vaccinated to avoid getting hepatitis A and spreading it to others.
* I might have been exposed to hepatitis A virus within the past 2 weeks.
* I received 1 dose of hepatitis A vaccine in the past, but I have not received the second dose (or I don’t remember if I have).
* I have not received hepatitis A vaccine in the past (or I don’t remember if I have) and at least one of the following applies to me:

• I travel (or plan to travel) in countries where hepatitis A is common.

• I have (or will have) contact with a child within 60 days of the child’s adoption from a country where

 hepatitis A is common.

• I am a man who has sex with men.

• I use street drugs.

• I have chronic liver disease.

• I have a blood clotting factor disorder.

• I work with hepatitis A virus in a research labo­ratory or with primates infected with hepatitis A virus.

**Hepatitis B vaccine** (check all that apply)

* I want to be vaccinated to avoid getting hepatitis B and spreading it to others.
* I am age 18 or younger and I have not begun or completed the series of hepatitis B shots (or I don’t remember if I have).
* I have received at least one dose of hepatitis B in the past, but I have not completed the series of hepatitis B shots (or I don’t remember if I have).
* I have not received or completed the series of hepatitis B shots (or I don’t remember if I have) and at least one of the following applies to me:

• I am sexually active and I am not in a long-term, mutually monogamous relationship.

• I am a man who has sex with men.

• I am an immigrant (or my parents are immi­grants) from an area of the world where hepati­tis B is

 common (so I need testing and may need vaccination.)

• I live with or have sex with a person infected with hepatitis B.

• I have been diagnosed with a sexually transmitted disease (STD).

• I have been diagnosed with HIV.

• I inject street drugs.

• I have chronic liver disease.

• I am or will be on kidney dialysis.

• I am younger than age 60 years and have diabetes and/or receive assisted glucose monitoring.

• I am a healthcare or public safety worker who is exposed to blood or other body fluids.

• I provide direct services to people with developmental disabilities.

• I am planning on traveling outside the U.S.

**AGENCY NAME**

Statement of Permission and Assignment: Hepatitis A and/or B Vaccination

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle

**Gender:** (circle) Male Female **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Number and Street**

**City: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone:** Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work/Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Language: (circle) English Spanish Other

**Race:** (circle) White Hispanic African American Asian Native American Other

**Insurance Information**

**€ Medicaid** Medicaid ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**€ Medicare** Medicare Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**€ No Insurance**

**€ Private Insurance** Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy # (or Subscriber ID#): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Group/Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pre-Vaccination Evaluation**

**I have read and understand** the information provided to me about receiving vaccines for Hepatitis A and/or B (Current VIS forms) and have had the opportunity to ask questions. I understand that if I have had a life-threatening reaction to a previous Hepatitis A or B vaccine or a severe allergy to components of the vaccine that I may not need to receive this vaccine.

**Allergies:** (please list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signed Patient Consent**

**By Signing Below: I hereby acknowledge** a copy of this agency’s “Notice of Privacy Practices” was available for me to read and or receive a copy. **I authorize (AGENCY NAME)** to submit a claim on my behalf (if applicable) to Medicare, Medicaid, and/or private insurance or other third party payor.  **I also authorize** release of any information necessary in processing my claim. I request payment be made to **(AGENCY NAME)** on my behalf.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- |
| **FOR AGENCY USE ONLY** |
| **€ List name of Vaccine Hep A (State) and Lot Number** | **Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Given By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Administration Site:** **€ Left Deltoid € Right Deltoid****Diagnosis Code: FILL IN CODE****Dosage and CPT Codes: € 1.0 mL Enter CPT Code Here** **€ 1.0 mL Enter CPT Code Here** |
| **€ List name of Vaccine Hep A (Private) and Lot Number** |
| **€ List Name of Vaccine Hep B (State) and Lot Number** |
| **€ List Name of Vaccine Hep B (Private) and Lot Number** |
| **Risk Factors Identified: € YES € NO** |
|  | **€ Entered in NCIR € Entered in EMR** |