HB Pharmacy

Vaccination Intake Sheet

Patient Information				
Patient Name:				Date:
Patient Address:				
City:	State:	Zip:	DOB:	Gender: M / F
Phone #:		Allergies:		
Alerternate Contact:		Relationship:		Phone:
Weight (circle one):	< 130 lbs	131 - 152 lbs	153 - 200 l	200 - 259 lbs > 260 lbs

HCPC	Product	DX	Dosage	Injection Site	Lot #	Exp.
90658	IIV: _____ ®	Z23	0.5 mL	L / R DELTOID IM		
	Boostrix ®	Z23	0.5 mL	L / R DELTOID IM		
	Shingrix ®	Z23	0.5 mL	L / R DELTOID IM		
	Prevnar ®	Z23	0.5 mL	L / R DELTOID IM		
	Pneumovax ®	Z23	0.5 mL	L / R DELTOID IM		
	Havrix 1440 unit ®	Z23	1 mL	L / R DELTOID IM		

Physician Information		
Ordering Physician: Eric Jackson		Physician Phone:
NPI 1235131251		Physician Fax:
Physician Address: 16-18 Ridge Road		
City: North Arlington	State: NJ	Zip: O7031

Administering Pharmacist		
Name:		
Address: 98 Ridge Road		
City: North Arlington	State: NJ	Zip: 07031

New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	***PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)***
Registrant Name *(Print)*	Name *(Print)*
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

☐ Yes, I would like to participate in this program.

☐ No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

HB Pharmacy Authorization Form – Medicare B

Statement to Permit Assignment of Benefits for Inactivated Injectable Influenza Vaccination

It is understood that HB Pharmacy has permission to ask for Medicare payments for medical care, including vaccinations.

It is understood that Medicare needs information about the patient and their medical condition to make a decision about payment. Permission is given for that information to go to Medicare and the companies that handle Medicare payment requests.

It is understood that the Centers for Medicare & Medicaid Services (CMS) is the government's Medicare agency. It is understood that a photocopy of this release is as valid as the original document. Furthermore, it is understood that responsibility for paying any deductible or co-insurance amounts are that of the patient's responsible party.

Therefore, it is asked that payment of authorized Medicare benefits be made on the patient's behalf to HB Pharmacy for any services or items furnished to the patient by HB Pharmacy. It is authorized that any holder of medical or other information about the patient release such information to the Centers for Medicare & Medicaid Services (CMS) and its agents as needed to determine these benefits or benefits payable for related services.

Name: _____

Signature: _____ Date: _____

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes ☐ no ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg d/p4065.pdf • Item #P4065 (4/18)

Notification of Vaccination Letter Template

Dear doctor or nurse at _____
PATIENT'S PRIMARY CARE CLINIC

We recently provided vaccination services to your patient. We want to make certain that you have information about the vaccines we administered so you can update your patient's medical record. Please contact us if you have any questions about this information.

☐ We provided the patient (or parent/guardian) with a written record of the vaccination(s) given.

☐ We entered information about the vaccine(s) we administered in the regional or state immunization information system.

Patient's name _____ Patient's birthdate ____
(MM/DD/YR)

(For a child, parent/guardian name _____ Parent/guardian birthdate ____)
(MM/DD/YR)

The vaccine(s) we administered on _____ is/are checked below.
DATE

VACCINES ADMINISTERED

☐ Hepatitis B
- ☐ Engerix-B, Recombivax HB
  DOSE (circle one): 0.5 mL 1.0 mL
- ☐ Heplisav-B (age 18 yrs and older)

☐ DTaP (age 6 yrs and younger)

☐ DTaP-HepB-IPV (Pediarix)

☐ DTaP-IPV (Kinrix, Quadracel)

☐ DTaP-IPV/Hib (Pentacel)

☐ DT (through age 6 yrs)

☐ Tdap (age 7 yrs and older)

☐ Td (age 7 yrs and older)

Hib (monovalent)
- ☐ ActHIB
- ☐ Hiberix
- ☐ PedvaxHIB

☐ IPV (Polio)

☐ Pneumococcal conjugate (PCV) (Prevnar 13)

☐ Pneumococcal polysaccharide (PPSV) (Pneumovax 23)

Rotavirus
- ☐ RV1 (Rotarix)
- ☐ RV5 (RotaTeq)

☐ Human papillomavirus (HPV) (Gardasil 9)

☐ MMR

☐ Varicella (chickenpox) (Varivax)

☐ MMRV (ProQuad)

☐ Hepatitis A (Havrix; Vaqta)
  DOSE (circle one): 0.5 mL 1.0 mL

☐ HepA-HepB (Twinrix)

Meningococcal ACWY
- ☐ MenACWY (Menactra, Menveo)

Meningococcal B
- ☐ Bexsero
- ☐ Trumenba

☐ Influenza
- BRAND _____
- DOSE (mL) _____
- ROUTE (circle one): IM ID NAS

Zoster (shingles)
- ☐ RZV (Shingrix, recombinant)
- ☐ ZVL (Zostavax, live)

☐ Other _____

HB Pharmacy
NAME OF CLINIC PROVIDING SERVICES

98 Ridge Road
ADDRESS

North Arlington, NJ 07031
CITY/STATE/ZIP

John C. Belicchi, RPh
CLINIC CONTACT PERSON

pharmacist@hbpharmacy.com
EMAIL ADDRESS

201-997-2010
PHONE

Technical content reviewed by the Centers for Disease Control and Prevention

IMMUNIZATION ACTION COALITION Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p3060.pdf • Item #P3060 (5/18)

Vaccine Administration Record for Adults

Patient name: _____

Birthdate: _____ Chart number: _____

Clinic name and address

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccine	Type of Vaccine[1]	Date given (mo/day/yr)	Funding source (F,S,P)[2]	Route[3] & Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[5] (signature or initials & title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Tetanus, Diphtheria, Pertussis (e.g., Td, Tdap) Give IM.[3]									
Hepatitis A[6] (e.g., HepA, HepA-HepB) Give IM.[3]									
Hepatitis B[6] (e.g., HepB, HepA-HepB) Give IM.[3]									
Human papillomavirus (HPV2, HPV4) Give IM.[3]									
Measles, Mumps, Rubella (MMR) Give SC.[3]									
Varicella (VAR) Give SC.[3]									
Pneumococcal (e.g., PCV13, conjugate; PPSV23, polysaccharide) Give PCV13 IM.[3] Give PPSV23 IM or SC.[3]									
Meningococcal (e.g., MenACWY, conjugate; MPSV4, polysaccharide) Give MenACWY IM.[3] Give MPSV4 SC.[3]									

See page 2 to record influenza, Hib, zoster, and other vaccines (e.g., travel vaccines).

How to Complete This Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (SC), intradermal (ID), intranasal (IN), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.
6. For combination vaccines, fill in a row for each antigen in the combination.

Abbreviation	Trade Name and Manufacturer
Tdap	Adacel (sanofi pasteur); Boostrix (GlaxoSmithKline [GSK])
Td	Decavac (sanofi pasteur); generic Td (MA Biological Labs)
HepA	Havrix (GSK); Vaqta (Merck)
HepB	Engerix-B (GSK); Recombivax HB (Merck)
HepA-HepB	Twinrix (GSK)
HPV2	Cervarix (GSK)
HPV4	Gardasil (Merck)
MMR	MMRII (Merck)
VAR	Varivax (Merck)
PCV13, PPSV23	Prevnar 13 (Pfizer); Pneumovax 23 (Merck)
MenACWY	Menactra (sanofi pasteur); Menveo (Novartis)
MPSV4	Menomune (sanofi pasteur)

Technical content reviewed by the Centers for Disease Control and Prevention

For additional copies, visit www.immunize.org/catg.d/p2023.pdf • Item #P2023 (4/14)

This form was created by the Immunization Action Coalition • www.immunize.org • www.vaccineinformation.org

VACCINE INFORMATION STATEMENT

Pneumococcal Conjugate Vaccine: *What You Need to Know*

Many vaccine information statements are available in Spanish and other languages See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Pneumococcal conjugate vaccine can prevent **pneumococcal disease.**

Pneumococcal disease refers to any illness caused by pneumococcal bacteria. These bacteria can cause many types of illnesses, including pneumonia, which is an infection of the lungs. Pneumococcal bacteria are one of the most common causes of pneumonia.

Besides pneumonia, pneumococcal bacteria can also cause:

- Ear infections
- Sinus infections
- Meningitis (infection of the tissue covering the brain and spinal cord)
- Bacteremia (infection of the blood)
- Anyone can get pneumococcal disease, but children under 2 years old, people with certain medical conditions or other risk factors, and adults 65 years or older are at the highest risk.

Most pneumococcal infections are mild. However, some can result in long-term problems, such as brain damage or hearing loss. Meningitis, bacteremia, and pneumonia caused by pneumococcal disease can be fatal.

2. Pneumococcal conjugate vaccine

Pneumococcal conjugate vaccine helps protect against bacteria that cause pneumococcal disease. There are three pneumococcal conjugate vaccines (PCV13, PCV15, and PCV20). The different vaccines are recommended for different people based on their age and medical status.

PCV13

- **Infants and young children** usually need 4 doses of PCV13, at ages 2, 4, 6, and 12–15 months.
- **Older children (through age 59 months)** may be vaccinated with PCV13 if they did not receive the recommended doses.
- **Children and adolescents 6–18 years of age** with certain medical conditions should receive a single dose of PCV13 if they did not already receive PCV13.

PCV15 or PCV20

- **Adults 19 through 64 years old** with certain medical conditions or other risk factors who have not already received a pneumococcal conjugate vaccine should receive either:
  - a single dose of PCV15 followed by a dose of pneumococcal polysaccharide vaccine (PPSV23), or
  - a single dose of PCV20.
- **Adults 65 years or older** who have not already received a pneumococcal conjugate vaccine should receive either:
  - a single dose of PCV15 followed by a dose of PPSV23, or
  - a single dose of PCV20.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention