COVID-19 Vaccine Worksheet

Patient Name _____ Date of birth: _____

Address _____ City: _____

State _____ Zip Code _____ Telephone _____ Gender: _____

Email address: _____

Insurance Name: _____

Group #_____ ID # _____

Insured person's name: _____ Insured person's DOB: _____

Vaccine Data Collection Questions	Yes	No
Are you Hispanic/Latino?		
What is your Race? White ☐ Black/African American ☐ Asian ☐ Hawaiian Native ☐ Pacific Islander ☐ American Indian/Alaskan ☐ Other ☐		
Have you worked as a Migratory/Seasonal Agricultural Worker within the last 24 months?		
Do you live in public housing or housing where you receive rental assistance?		
Are you homeless, at risk or homelessness, or your primary residence a shelter, transitional housing, or other temporary living setting?		
What is your preferred language? _____		

I have received the **Fact Sheet for Recipients and Caregivers**, have had the opportunity to ask questions regarding the vaccine being administered, and these questions were answered to my satisfaction. I understand the benefits and risks of the vaccine and hereby authorize administration of the vaccine.

Patient Rights and Responsibilities: I have been given access to, and may have a copy of, the Terry Reilly Patient Rights and Responsibilities.

Notice of Privacy Practices: I have been given access to, and may have a copy of, the Terry Reilly Notice of Privacy Practices.

Health Information: I understand that my health information may be shared across the Terry Reilly dental, medical and behavioral health divisions.

Idaho Health Data Exchange (IHDE): I understand that Terry Reilly is a member of the IHDE, a secure internet-based health information exchange for improving quality coordination of health care in Idaho. I understand I may "opt out" from the IHDE by completing a Requests to Restrict Disclosure of Health Information and submitting it directly to IHDE by mail or fax or am able to contact IHDE at (208) 332-7253.

Partner Data Access Program (PDAP): Terry Reilly Health Services may access my information from the Idaho Department of Health and Welfare Partner Data Access Program (PDAP) to determine my eligibility for discounts on healthcare.

Receipt of family planning services is not a prerequisite to receive of any other services offered.

Terry Reilly Health Services *is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org as a business associate of Adapt Oregon OCHIN supplies information technology and related services to* ***Terry Reilly Health Services*** *and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by* ***Terry Reilly Health Services*** *with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement. Health care operation can include, among other things, geocoding your residence location to improve the clinical benefits you receive. The personal health information may include past, present and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.*

Signature of patient X_____ Date: _____

Patient is a minor: Name of parent/guardian: _____

Relationship to minor: _____ Date of birth of responsible party: _____

COVID-19 Vaccine Worksheet

Patient Name _____Date of birth: _____ Age: _____

For vaccine recipients: The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked.** If a question is not clear, please ask your healthcare provider to explain it.

Vaccine Administration Screening Questions	Yes	No
Are you feeling sick today? (May need to defer vaccine, based on severity)		
Have you ever received a dose of COVID-19 vaccine?		
If yes, which one: Pfizer ☐ Moderna ☐ Janssen ☐ Other ☐ Date of last dose? Did you bring your vaccine card?		
Have you ever had a **severe** allergic reaction to another vaccine (other than Covid-19 vaccine) or an injectable medication? (Consult treating clinician before administering vaccine)		
Do you have any questions about the COVID-19 vaccine that you want answered today?		
Have you ever had an allergic reaction to a component of the Covid-19 vaccine including either of the following? (Consult treating clinician before administering vaccine) ☐ Polyethylene glycol (PEG), which is found in some medications, such as laxatives for colonoscopy procedures ☐ Polysorbate, which is found in some vaccines, film coated tablets and intravenous steroids ☐ A previous dose of Covid-19 vaccine		

Check all that apply:

☐ I am a female between the ages 18-49 years old (Avoid J&J vaccine)

☐ I've had a **severe allergic reaction** to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication (Observe for 30 minutes)

☐ I've had Covid-19 and was treated with monoclonal antibodies or convalescent serum in the past 90 days (If Evusheld™ (tixagevimab/cilgavimab) was given, defer vaccine for at least two weeks. Otherwise, may receive vaccine.)

☐ I am diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a Covid-19 infection (Consult treating clinician)

☐ I have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies (May still receive vaccine)

☐ I have a history of risk factor for a bleeding disorder (Avoid J&J vaccine)

☐ I'm taking a blood thinner (Apply pressure after administration)

☐ I have a history of Guillen Barre syndrome (Avoid J&J vaccine)

☐ I have a history of heparin-induced thrombocytopenia (HIT) (Consult treating clinician)

☐ I am currently pregnant or breastfeeding (May still receive vaccine)

☐ I have received dermal fillers (Observe for 30 minutes)

☐ I am a **Terry Reilly Employee** and I authorize this form to be placed in my confidential employee health file as proof of my vaccination

**** Office Use Only ****

Site: R ____ L ____ Deltoid Dose 1: ___ Dose 2: ___ Dose 3: _____ Dose 4: _____ ☐ Vaccine Card Provided

☐ Moderna COVID-19 Vaccine (over 18) 0.5ml
☐ Pfizer-BioNTech COVID-19 Vaccine (over 12) 0.3ml
☐ Janssen COVID-19 Vaccine (over 18) 0.5ml
☐ Pfizer-BioNTech COVID-19 Vaccine (5-11) 0.2ml
☐ Moderna COVID-19 Vaccine Booster (over 18) 0.25ml
☐ Pfizer-BioNTech COVID-19 Vaccine Booster (over 12) 0.3ml
☐ Janssen COVID-19 Vaccine Booster (over 18) 0.5ml

Lot#: _____ Exp. Date: _____ (check QR Code on Moderna vaccine vial for exp. date)
Vaccine administered by: _____ Date: _____ Entered into EHR ☐
Notes: _____