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, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☐	☐
5. Do you, or does a close family member, 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 (4/19)

Whitman County Public Health

310 N Main St, Ste 108
Colfax, WA 99111

1205 SE Pro Mall Blvd, Ste 203
Pullman, WA 99163

INTAKE FORM

Today's Date _____ **Location** ☐ Colfax ☐ Pullman ☐ Other _____

Client Name _____ **Phone** _____
(Last) (First) (Middle)

Client Address _____
(Street/P.O. Box) (City) (State) (ZIP)

Date of Birth _____ **Age** _____ **Sex** ☐ Male ☐ Female ☐ Transgendered

Race (Optional) ☐ Caucasian ☐ Native American ☐ Asian/Pacific ☐ African American ☐ Hispanic ☐ Other

My signature authorizes immunization and/or TB skin testing services to be provided by a Whitman County Public Health Nurse.
Authorized signature (Client/Guardian) _____

Complete if requesting sliding fee scale

Number in Household _____ Gross Household Income _____ ☐ Monthly ☐ Bi-monthly ☐ Annually

PLEASE DO NOT WRITE BELOW THIS LINE

90471	Vaccine Administration Fee x1 vax	20.00
90472	Vaccine Administration Fee x2+ vax	30.00
86580	TB Test, 1 Step Office Visit	45.00
86580	TB Test, 2 Step Office Visit	55.00

Diagnostic Code (Circle)

Z23	Encounter for Immunization
Z11.1	Encounter for TB Screening

(32.01) Immunization Service - State Child Vaccines

90702-SL	DT	-
90700-SL	DTaP	-
90723-SL	DTaP/HBV/IPV *(Pediarix)*	-
90696-SL	DTaP/IPV *(Kinrix/Quadracel)*	-
90698-SL	DTap/HIB/IPV *(Pentacel)*	-
90633-SL	Ped Hep A	-
90744-SL	Hep B	-
90648-SL	HIB prp-t	-
90651-SL	Gardasil *(HPV)*	-
90657-SL	Influenza Injection (6-35 months)	-
90658-SL	Influenza Injection (3-18 years)	-
90672-SL	Influenza Flumist Nasal Spray (2-18 years)	-
90713-SL	IPV	-
90707-SL	MMR	-
90710-SL	MMRV	-
90669-SL	PCV-13	-
90680-SL	Rotavirus	-
90718-SL	Tetanus/TD	-
90715-SL	Tdap	-
90716-SL	Varicella	-
90734-SL	Meningococcal *(Menactra)*	-

(32) Immunization Service - Adult Private

90632	Hep A Adult (19+ years)	45.00
90739	Hep B/Hepisav (19+ years)	125.00
90658	Influenza Injection	25.00
90718	Tdap	48.00
90707	MMR	80.00

VFC Eligible?
- ☐ Medicaid/Medicaid Managed Care
- ☐ Uninsured
- ☐ American Indian/Alaskan Native
- ☐ Underinsured
- ☐ CHIP
- ☐ Private Insurance

Amount Due $_____
Sliding Fee Scale A B C D

Payment
- ☐ Check Check # _____
- ☐ Cash Receipt # _____
- ☐ Credit/Debit Order # _____
- ☐ Bill to _____

LPN: Deanna ☐ ☐

Action (initial)

Billed _____ **Invoice #** _____ **Date** _____ **WAIIS** _____ **Date** _____
Client Management _____ **Date** _____