COVID-19 Vaccine Booster/Third Dose Intake Form

CIMPAR
CHICAGO INTERNAL MEDICINE PRACTICE AND RESEARCH

Is the patient 65+ y.o.? ○YES ○NO
Is the patient a health care worker? ○YES ○NO

Last Name | First Name | Date of Birth | Gender

Address | City | State | Zip

Patient Email | Patient Phone #

Race: ☐**1** - American Indian or Alaska Native ☐**2** - Asian ☐**3** - Native Hawaiian/Other Pacific Islander ☐**4** - Black or African American ☐**5** - White ☐**6** - Other Race

Ethnicity: ☐**1** - Hispanic ☐**2** - Not Hispanic or Latino ☐**3** - Unknown

Insurance Information:

Medical Insurance: *Medical Insurance Provider | *Cardholder ID # | *Group ID | *Payer ID

○ Yes ○ No

*Is the patient the primary cardholder? | ***If no**, include primary cardholder's DOB

***If uninsured, you must check the box below to attest that the following information is true and accurate:**

○ I I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government-funded health benefit plan.

In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, please provide either (a) a valid Social Security number, (b) state identification number and state of issuance, OR (c) a driver's license number and the state of issuance.

*Social Security Number | or State Identification Number & State | or Driver's License Number & State

Potential Contraindications

	YES	NO	DON'T KNOW
1. Are you feeling sick today?	○	○	○
2. Have you ever received a dose of COVID-19 vaccine?	○	○	○
If yes, which vaccine product? ○Pfizer ○Moderna ○Another product: _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) in the past? *Example: a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?*	○	○	○
4. Do you have a weakened immune system, as defined by the following guidelines: *Been receiving active cancer treatment for tumors or cancers of the blood, Received an organ transplant and are taking medicine to suppress the immune system, Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system, Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome), Advanced or untreated HIV infection, Active treatment with high-dose corticosteroids or other drugs that may suppress your immune response*	○	○	○
5. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days?	○	○	○
6. Do you have a bleeding disorder or are you taking a blood thinner?	○	○	○

Emergency Use Authorization: The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call clinic, contact doctor, call 911. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request. State of Georgia only: I verify a pharmacist asked for my health history and whether I have had a physical exam within the past year. Health care providers did not identify condition(s) that would mean I should not receive vaccine(s).

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize CIMPAR to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that CIMPAR may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at CIMPAR (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that CIMPAR will use and disclose my health information as set forth in the CIMPAR Notice of Privacy Practices (copy is available in clinic, online or by requesting a paper copy from the pharmacy). State of California only: I agree to have CAIR share my immunization data with Health Care Providers, agencies or schools. Vaccine Clinics: If I am receiving a vaccine through a vaccine clinic, I understand that my name, vaccine appointment date and time will be provided to the clinic coordinator.

X _____ Date

Signature of patient to receive vaccine (or parent, guardian, or authorized representative)

If signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient.

Name of parent, guardian, or authorized representative | Phone Number | Relationship

Vaccine Administration Information for Immunizer/Pharmacist use only

Administration Date	Vaccine	VIS Date	Manufacturer ○ L ○ R	Volume (mL)
Lot #	Exp. Date	Route	Site	

Administering Immunizer Name & Title | Administering Immunizer Signature