

McLaren Print System Order

Order No: 72253 Reprint Previous Order No: 5506
Order Date: 2022-09-09
User: Carrie Gnatkowski
Phone: 989-393-2714

Ship Location: McLaren Bay Primary Care Attn: Carrie Gnatkowski
4 Columbus Ave., Suite 380
Bay City , MI 48708

Forms

Quantity: 100
Paragon Dept No: 17805
Dept Name: McLaren Medical group
Company Number: 810

Order Total Price: 23.40

Item Number: MM-474
Item Description: Influenza Consent Form
Revision Date: 8/2021
Print: 1 sided black and white
Paper: 2 Part (White, Yellow)
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info: This form must be ordered with DCH-0457

McLaren MEDICAL GROUP
INFLUENZA VACCINE & ADMINISTRATION FORM
Last Name, First Name, Sex, Middle Initial, Address, City, State, Zip, Telephone, Primary Care Provider (PCP)
Not all individuals receiving the influenza vaccine can be safely vaccinated. Please complete the following questions to evaluate any contraindications to the influenza vaccine.
1. Do you have any current or recent allergic reactions?
2. Have you ever had a severe allergic reaction to a previous influenza vaccine or any of its components?
3. Do you have a fever or acute illness?
4. Do you have a past history of Guillain-Barre Syndrome?
5. Do you have a history of seizures or bleeding? (for intranasal administration only)
As with any medication, there are risks and possible side effects/reactions. Side effects/reactions of influenza vaccine are generally mild, usually occur soon after vaccination and can persist for 1-2 days. In rare cases, side effects/reactions of influenza vaccine may include empty/hoarse and voice loss. If you think you are having a severe reaction or other emergency, SEEK MEDICAL CARE IMMEDIATELY.
I have received and reviewed the Influenza Vaccine Information Statement (ISVIS) and have had the opportunity to ask questions. I have been advised to remain under observation for at least 15 minutes following vaccination. I understand the benefits and the risks of the influenza vaccine as described. I hereby agree to receive and hold McLaren Medical Group, its employees, agents and representatives, harmless from further responsibility with regard to my receiving the vaccine. I request the influenza vaccine to be given to me or to the person named for whom I am authorized to sign.
Signature of Patient or Authorized Representative (include relationship), Date
Check staff. For any YES response and an active patient, review with the provider. Otherwise, refer patient back to their PCP. I have reviewed and authorize vaccine administration. Provider Signature, Date, Time
McLaren Medical Group will continue to administer your influenza vaccine today due to a contraindication. Please take a copy of this form to your Primary Care Provider.
FOR MEDICARE PATIENTS ONLY
I request that this provider be paid authorized Medicare benefits on my behalf for any services furnished to me. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits for related services. I understand that I am responsible for the charges if my Medicare coverage is not appropriate. Medicare Number
Patient Signature, Payment to Patient, Payment to Provider
Sex of Injection, Lot Number, Manufacturer, Expiration Date, Administered by, Date, Time
INFLUENZA CONSENT FORM - Original - Cassa Cassa - Patient MM-474 Rev. 8/2021