MaineHealth
CARE AT HOME

MHCAH Flu Clinic – Patient Registration

PATIENT INFORMATION

FIRST NAME	LAST NAME	GENDER	
		☐ FEMALE ☐ MALE	
DATE OF BIRTH (MM/DD/CCYY)	**SOCIAL SECURITY NUMBER**	**PHONE NUMBER W/ AREA CODE**	
STREET ADDRESS	**TOWN/CITY**	**STATE**	**ZIP CODE**
INTERPRETER REQUIRED?	**PREFERRED LANGUAGE?**	**YOUR PRIMARY DOCTOR / PCP?**	
☐ NO ☐ YES			
EMERGENCY CONTACT:			

PATIENT/SUBSCRIBER INSURANCE

	PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insurance		
Relationship to Subscriber		
Insurance ID #		
Effective Date		

Screening questions:	NO	YES
1. Have you ever had a flu shot or flu-mist? (If not, we recommended that you stay in the area for about 15 minutes after receiving the vaccine).	☐	☐
2. Have you had a severe reaction to a previous influenza vaccine?	☐	☐
3. Are you allergic to eggs or chicken?	☐	☐
4. Do you have a past history of Guillian-Barre Syndrome?	☐	☐
5. Do you have a chronic disease?	☐	☐
6. Are you sick with a fever?	☐	☐

***Note:** If the "Flu-mist" option is chosen or recommended, there will be other screening questions that your nurse will discuss with you.

I have been provided a copy of **the "Inactivated" injection or the "Live" intranasal Influenza Vaccine Sheet** and had the opportunity to ask questions. I understand the benefits and risks of the influenza vaccine as described. I request that the vaccine be given to me or to the person named for whom I am authorized to sign. I acknowledge that no guarantees have been made concerning the results of the vaccine. I hold harmless, MaineHealth Care at Home, its employees, and the facility in which the vaccine was received. I request that payment of authorized benefits be made on my behalf directly to MaineHealth Care at Home. I AGREE TO PAY THE AMOUNT(S) NOT PAID OR IF MY CHARGES ARE DENIED FOR ANY REASON. I hereby acknowledge my understanding of MaineHealth Care at Home's Notice of privacy practices.

_____ _____ _____

Patient/Guardian or Auth Representative **Reason patient is unable to sign** **Date**

<u>Injection documentation below to be completed by nurse</u>:

Dose 0.5 ml 0.25 ml Deltoid / VL injection site L / R (please circle) or Flu-mist

Vaccine:_____ **Expires:** _____ **Lot #**_____

Time of admin _____ **am/pm** **Comment: (if needed)** _____

Nurse's signature:_____ **Date:**_____