WESTERN CONNECTICUT HOME CARE

DANBURY HOSPITAL • NEW MILFORD HOSPITAL

FLU PREVENTION PROGRAM

STAFF USE
☐ CT State Clinic
Clinic Site: _____
Verified by: _____

2012 ADULT INFLUENZA IMMUNIZATION CONSENT

PLEASE COMPLETE FORM IN LEGIBLE PRINT

Patient Name (As it appears on insurance card)	Gender ☐ M ☐ F	Date of Birth: _____/_____/_____

Address:			
No. and Street Name (No PO Box Please)	City	State	Zip

Home or Cell Phone:	Work Phone:

PRIMARY INSURANCE INFORMATION: Please check your insurance; fill in your insurance ID# and policyholder's name.

- ☐ Aetna
- ☐ Aetna Medicare Advantage
- ☐ Anthem/Blue Cross / ☐ *CT State Employee Plan*
- ☐ Anthem Medicare Advantage
- ☐ Blue Cross *(other than Anthem)*
- ☐ Cigna
- ☐ ConnectiCare
- ☐ ConnectiCare Medicare VIP
- ☐ Medicare Part B
- ☐ Medicaid (Husky B/SCHIP) (18 year olds only)
- ☐ MultiPlan Network
- ☐ Oxford / ☐ *CT State Employee Plan*
- ☐ Oxford Medicare

Insurance ID#: _____

Policy Holder (not company) if other than patient:

_____

Direct Payment:

☐ Other insurance not listed or No insurance coverage

Paid by: ☐ Cash ☐ Check #_____ ☐ MC ☐ VISA

Amount Paid: _____

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Add'l Medicare Supplement Plan: _____

Policy #: _____

I understand I will receive a bill from WCHC for any portion of this claim my insurance company does not pay and I agree to pay the bill in full within 30 days of receipt.

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Are you allergic to eggs or to the preservative thimerosal? ☐ Yes ☐ No
2. Have you ever had a reaction to any vaccine? ☐ Yes ☐ No
3. Have you ever been diagnosed with Guillain-Barré Syndrome? ☐ Yes ☐ No
4. Are you sick with a fever today? ☐ Yes ☐ No
5. If you **are age 65 or older**, are you interested in the Sanofi High Dose flu vaccine? ☐ N/A ☐ Yes ☐ No
6. If you are **under age 50**, are you interested in receiving FLUMIST? ☐ N/A ☐ Yes ☐ No

   If you answered YES to question #6, please answer the following questions, otherwise skip.

   a. Do you or anyone living with you have a severely compromised immune system? ☐ Yes ☐ No

   b. Are you in close contact at work or otherwise with someone who has had a transplant or has a comprised immune system? ☐ Yes ☐ No

   c. Do you have chronic health issues such as: diabetes; heart, lung, kidney or liver disease; COPD or asthma? ☐ Yes ☐ No

   d. Are you pregnant or is there a chance you might be pregnant? ☐ Yes ☐ No

   e. Do you suffer from a muscle or nerve disorder such as seizure disorders or cerebral palsy? ☐ Yes ☐ No

   f. Have you been immunized with a live vaccine (MMR, varicella) within the past 4 weeks? ☐ Yes ☐ No

I have read the Influenza Vaccine Information Statement dated 07/02/2012. I have had a chance to ask questions and I understand the benefits and risks of the vaccine. I request that the vaccination be given to me (or to the person for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process the insurance claim or for other public health purpose. I have read the Notice of Privacy Practices. I agree to pay all unpaid charges billed to me by Western Connecticut Home Care.

Signature: _____ Print Name: _____

STAFF USE ONLY

Place vaccine label here or complete: Vaccine Brand:_____ Lot #: _____ Exp. Date:_____

☐ Standard ☐ FluMist ☐ T-Free ☐ High Dose

Site: ☐ L Arm ☐ R Arm ☐ Intranasal	Administered by:	Date: _____ /_____ / 2012