

**PATIENT ASSESSMENT/DOCUMENTATION FOR ADULT INFLUENZA VACCINATION**

Effective Annually: October 1st through March 31st

(Influenza Vaccine Standing Order Policy & Procedure. Medical Director signature can be found in administration.)

**PATIENT INFORMATION**

Facility Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

Patient Assessed by: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**CRITERIA FOR WHICH INFLUENZA VACCINE IS STRONGLY ENCOURAGED:**

- ◆ All persons ages 19 – 49 with Chronic Cardiac Disease, Chronic Liver Disease, Chronic Pulmonary Disease (including asthma), Diabetes, Renal Failure, Blood Disorders, or Immunosuppression
- ◆ All persons age 50 and older
- ◆ Healthcare workers or Caretakers of high-risk patients
- ◆ Residents of nursing homes or chronic care facilities
- ◆ All pregnant women

**If patient meets any of the above criteria but is uncertain about prior vaccination status, or history is unreliable - vaccination recommended.**

**CONTRAINDICATIONS:**

**Trivalent inactivated influenza vaccine (TIV) – Recommended for persons under age 5 and 50 yrs and older**

Previous anaphylactic reaction to this vaccine, to any of its components, or to eggs Yes or No

**Live attenuated influenza vaccine (LAIV) – Recommended for healthy persons, ages 5-49 yrs**

Previous anaphylactic reaction to this vaccine, to any of its components, or to eggs Yes or No

Pregnancy, asthma, restrictive airway disease, or other pulmonary or cardiovascular system disorder Yes or No

Underlying medical condition such as diabetes, renal dysfunction, hemoglobinopathy Yes or No

Known/suspected immune deficiency disease or receiving immunosuppressive therapy Yes or No

History of Guillain-Barre syndrome Yes or No

**If Yes is answered for ANY question regarding contraindications, STOP ASSESSMENT HERE AND DO NOT GIVE VACCINE  
People who are contraindicated to LAIV consider/offer TIV if not contraindicated.**

**PRECAUTIONS (TIV and LAIV):**

Patient has moderate to severe acute illness with or without fever Yes or No

**If Yes, vaccinate immediately upon improvement - prior to discharge from hospital**

**VACCINE ADMINISTRATION (TIV and LAIV):**

**If vaccine is indicated, and there are no contraindications, then**

**VIS** Yes or No  
**Edition date on VIS** \_\_\_\_\_

ADMINISTER 0.5 ml Influenza Vaccine IM in deltoid or triceps

➔ Observe patient for 15 minutes after injection for possible reaction

No adverse drug reaction (ADR) noted after 15 minutes

ADR noted - description and treatment: \_\_\_\_\_

Date of vaccine administration: \_\_\_/\_\_\_/\_\_\_ Time of vaccine administration: \_\_\_\_\_

Site: \_\_\_\_\_ Route: \_\_\_\_\_

Manufacturer: \_\_\_\_\_ Lot #: \_\_\_\_\_

Vaccine administered by: \_\_\_\_\_

**FLU SHOT INDICATED BUT NOT GIVEN BECAUSE:**

- Patient believes vaccine will cause disease
- Believes not at risk for disease
- Other \_\_\_\_\_
- Believes vaccine won't work
- Fear of adverse effects
- \*Notify physician if patient declines*
- Wants further advice
- Would rather receive elsewhere