IMMUNIZATION REQUEST

2018

Southwest Pharmacy 2402 West Pierce Suite 1A, Carlsbad, NM 88220

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PATIENT INFORMATION:

Patient Name:_____D.O.B.:_____ Sex: M or F

Address: _____ City:_____ State:_____ Zip:_____

Phone: _____ Email:_____

Physician:_____

BILLING INFORMATION	CASH	MEDICARE	OTHER
PRESCRIPTION INSURANCE CARD		Express: NMPSIA	Express: State of NM

ID # _____

Circle One: Cardholder Spouse Child

* Immunizations are **NOT FREE** but offered as a benefit covered under Express prescription insurance with no co-payment required.

ANSWER QUESTIONS AND SIGN WAVER:

1. Are you sick today? Fever? Diarrhea? Y N
2. Do you have allergies to medications (neomycin,etc.), food (eggs), or any vaccine? Y N
3. Have you ever had a serious reaction after receiving a vaccination? Y N
4. Do you have cancer, leukemia, AIDS, or any other immune system problem? Y N
5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments? Y N
6. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? Y N
7. For women: Are you pregnant or is there a chance you could become pregnant during the next month? Y N
8. Have you received any vaccinations in the past 4 weeks? Y N

I authorize Southwest Pharmacy Pharmacists to prescribe, administer and bill for immunizations requested and have provided accurate and current insurance information for insured dependents and/or agree to be financially liable for all vaccinations and administration fees for uninsured patients and/or their dependants. I acknowledge that the pre-vaccination questionnaire has been answered truthfully and honestly to the best of my ability. I have read and understand the Vaccination Information Statement (VIS) available at http://www.immunize.org/vis/ . I authorize the release of these immunization records to my physician and the New Mexico Department of Health.

Patient Signature: _____**Date:** _____

SELECT IMMUNIZATIONS YOU NEED BY CHECKING THE BOX TO THE LEFT OF THE NAME:

	Vaccine	Date	Site	By	Vaccine	Lot #	Exp. Dt.	VIS date
	FLU				Flucelvax	252225	May312019	8/7/15
	Pneumococcal (IM)				Pneumovax 23			4/24/15
	Pneumococcal (IM)				Prevnar 13			11/5/15
	Tet/Diphth/Pertussis (IM)				Adacel			2/24/15

Prescribed By: _____