IN COVID-19 Vaccine Questionnaire, Record and Prescription

meijer pharmacy

PATIENT INFORMATION Please print clearly.

Patient Name: _____ Date of Birth: ___ /___ /_____ Age: _____

Phone#: (_____) _____ Address: _____

Gender: _____ Weight: ❒ 33-66 lbs ❒ >67 lbs City: _____ State: _____ Zip: _____

Ethnicity: ❒American Indian/Alaska Native ❒Asian ❒Black/African American ❒Native Hawiian/Other Pacific Islander ❒ Other Race ❒ White
Are you of Hispanic, Latino, or Spanish origin? ❒ Yes ❒ No

If you would like us to fax your Primary Care provider to inform them of this vaccine, please provide your primary care providers name and fax number(Optional):

Primary Doctor: _____ Dr. FAX #: (_____) _____

SCREENING QUESTIONS

		We use the answers to these questions to determine if you are eligible for your vaccine.	Yes	No	Unsure
COVID-19 Vaccines	1.	Are you a healthcare provider, healthcare personnel, or do you work in a healthcare facility?	❒	❒	❒
	2.	Except for healthcare workers, are you an essential worker? (examples: Education, food and agriculture, utilities, first responders, correction officers, or transportation)	❒	❒	❒
	3.	Do you have a compromised immune system or any of the following conditions? Chronic heart, lung, or kidney disease, diabetes, obesity, cancer, sickle cell disease, or are you a transplant patient or a smoker?	❒	❒	❒
	4.	Are you sick today?	❒	❒	❒
	5.	Have you ever received a dose of COVID-19 vaccine?	❒	❒	❒
	6.	Have you received any other vaccines in the last 14 days?	❒	❒	❒
	7.	Are you currently under quarantine for COVID-19 illness or exposure?	❒	❒	❒
	8.	In the last 90 days, have you received passive antibody (monoclonal antibodies or convalescent serum) as a treatment for COVID-19?	❒	❒	❒
	9.	Have you ever had an allergic reaction to a previous COVID-19 vaccine, polyethylene glycol (PEG), which is found in laxatives used for colonoscopy procedures, or polysorbate?	❒	❒	❒
	10.	Have you ever had an allergic reaction or fainted after receiving any vaccination or injectable medication?	❒	❒	❒
	11.	Have you ever had a severe allergic reaction to medications, food, insects, etc.?	❒	❒	❒
	12.	Do you have a weakened immune system caused by something such as cancer, leukemia, HIV or other immune system problem?	❒	❒	❒
	13.	In the past 3 months have you taken cortisone, prednisone, other steroids, biologics, anticancer drugs, or have you had radiation therapy?	❒	❒	❒
	14.	For women: Are you pregnant or breastfeeding?	❒	❒	❒

IMPORTANT INFORMATION

To comply with public health regulations, we will report your COVID-19 vaccine to the statewide immunization registry. You will receive a vaccine Fact Sheet to read, have all your questions answered before you receive your vaccine. Any claims arising out of this service must be brought through the Covered Countermeasures Process Fund.

PARENT/LEGAL GUARDIAN CONSENT FOR MINOR

- Parent/legal guardian **signature** (if patient is a minor): _____ Date: ___ /___ /___
- Printed parent/legal guardian **name**: _____ Phone#: (_____) _____

Meijer Pharmacy complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color national origin, age, disability, or sex. If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-543-3704. **ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-543-3704. **注意：**如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-543-3704。

FOR PHARMACY USE ONLY

Vaccine	Dose/Sig Code		Brand Name	Lot	Exp.	Age	Dosage	Site of Injection
COVID-19 Vaccine	❒COV1 ☑COV2	☑	*Pfizer-BioNTech®*	ER2613	6/2021	≥ 16 yo	0.3mL	IM L / R Deltoid
		❒	*Moderna®*			≥ 18 yo	0.5mL	IM L / R Deltoid
		❒	_____				____	
Prescriber Info:		**Dr. Kamaldeep Singh Heyer, MD** NPI: 1205149952 I IN License: 01072417A			21731 NE 201st CT, Woodinville, WA 98077 Phone: (800) 792-5972			

EmpID: _____ Team member title: RPh / Intern / Tech Team member identified themselves to patient ❒

Printed name of supervising pharmacist: _____

- Medicare Part D and Medicare Advantage plans will not cover the COVID vaccine, these claims **MUST** be billed through Medicare Part B. Collect the patient's Medicare Part B ID number or the last 4 of their Social Security Number.
- When collecting Medical coverage, indicate which plan it is: BCBS, Aetna, Cigna etc.

FOR PHARMACY USE ONLY

For patients with insurance, Meijer will need to bill your insurance. People without health insurance or whose insurance does not provide coverage of COVID-19 vaccines can also get a COVID-19 vaccine at no cost.

Does the patient have insurance? YES □ NO □	
Patients born on or before 1956	
Medicare Part B ID (MBI):	
Last 4 Digits of SSN:	
RX Insurance	
Member ID:	
RX BIN:	
RX GROUP:	
RX PCN:	
Person Code:	
Medical Insurance	
Plan Name:	
Member ID w/ prefix:	
GROUP Number:	
Uninsured Patients	
Driver's License or State ID:	