



ARROWHEAD REGIONAL MEDICAL CENTER
Primary Care Centers Policies and Procedures

POLICY NO. 592.00 Issue 01
Page 1 of 6

SECTION:	PATIENT CARE	SUB SECTION:	MEDICATIONS
SUBJECT:	ADMINISTERING INFLUENZA & PNEUMOCOCCAL VACCINES TO ADULTS		
APPROVED BY:	<hr/>		

Clinical Director I, Ambulatory Services

POLICY

It is the policy of Arrowhead Regional Medical Center to screen, offer and provide the influenza and pneumococcal vaccination to all adult outpatients of clinics and centers that provide primary care, who fit the criteria and do not have any contraindications for the influenza or pneumococcal vaccine. Specialty clinics are to screen, offer and provide the influenza vaccination only.

Under this policy and procedure Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) with proper training may provide the influenza and pneumococcal vaccinations to patients who fit the criteria below. Federal and State regulations authorize both RNs and LVNs to immunize patients for Influenza and Pneumococcal disease without a physician's order.

PROCEDURES

INFLUENZA VACCINE

- I. Assess Adults for Need of Vaccination Against Influenza:
 - A. All adults are recommended to receive influenza each year.
 - B. Women who are or will be pregnant during the influenza season. Administer any recommended, age appropriate inactivated influenza (IIV) or recombinant influenza (RIV) to pregnant women in any trimester.
 - C. People who do not recall whether they received influenza vaccine this year should be vaccinated.
 - D. If there is a flu vaccine shortage, prioritize these groups of people:
 1. Chronic lung disease, including asthma
 2. Chronic heart or kidney disease
 3. Diabetes or other metabolic diseases
 4. Immunosuppression (HIV or medications)
 5. Hematologic disorders
 6. Diseases impacting breathing or creating a risk of aspiration (seizure disorder, neuromuscular disorders, spinal cord injury, severe cognitive disorders).
 7. Pregnant women (need preservative free flu vaccine).
 8. People in close contact with high risk populations including: healthcare workers, caregiver or household member, caretakers of or people living with a child 0-6 years or an adult age 50 years or older.

II. Screen for Contraindications and Precautions:

A. Contraindications for use of all influenza vaccines

1. Do not give influenza vaccine to a patient who has experienced a serious systemic or anaphylactic reaction to a prior dose of any influenza vaccine or to any of its components (except egg).
2. For a list of vaccine components, refer to the manufacturer's package insert.

B. Contraindications only for use of live attenuated influenza vaccine (LAIV: FluMist, nasal spray):

1. Do not give live attenuated influenza vaccine to a patient who:
 - a. Is pregnant
 - b. Is immunocompromised due to any cause (including immunosuppression caused by medications or HIV infection)
 - c. Is age 50 years or older
 - d. Received influenza antivirals (e.g. amantadine, rimantadine, zanamivir, oseltamivir or peramivir) within the previous 48 hours
 - e. Is a close contact of or who provides care for a severely immunosuppressed person who requires a protective environment.

C. Precautions for use of all influenza vaccines:

1. Moderate or severe acute illness with or without fever
2. History of Guillain-Barre syndrome within 6 weeks of a previous influenza vaccination.

D. Precautions for use of LAIV only:

1. Asthma
2. Other chronic medical conditions that might predispose the patient to complications of influenza infection (e.g. other chronic pulmonary, cardiovascular, renal, hepatic, neurologic, hematologic, or metabolic disorders).

E. Complete Influenza/Pneumococcal Vaccine Consent/Order (Attachment A).

III. Vaccine Information Statements:

- A. Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS).
- B. Provide non-English speaking patients with a copy of the VIS in their native language.
- C. Vaccine Information Statements can be found at www.immunize.org/vis

IV. Prepare to Administer Vaccine:

- A. For vaccine that is to be administered intramuscularly, choose the needle gauge, needle length, and injection site according to the following chart:

Gender and weight of patient	Needle gauge	Needle length	Injection site
Female or male less than 130 lbs	22–25	5/8"–1"	Deltoid muscle of arm
Female or male 130–152 lbs	22–25	1"	Deltoid muscle of arm
Female 153–200 lbs	22–25	1–1½"	Deltoid muscle of arm
Male 153–260 lbs	22–25	1–1½"	Deltoid muscle of arm
Female 200+ lbs	22–25	1½"	Deltoid muscle of arm
Male 260+ lbs	22–25	1½"	Deltoid muscle of arm

* A 5/8" needle may be used in patients weighing less than 130 lbs (<60 kg) for IM injection in the deltoid muscle only if the skin is stretched tight, the subcutaneous tissue is not bunched, and the injection is made at a 90-degree angle to the skin.

B. For vaccine that is to be administered intranasal, prepare the vaccine according to the directions in the package insert.

V. Administer Influenza Vaccine:

A. Administer influenza vaccine according to the criteria and guidance in the table below:

Type of vaccine	Age group	Dose	Route	Instructions*
Inactivated influenza vaccine (IIV)	All ages	0.5 mL	Intramuscular (IM)	Administer vaccine in deltoid muscle.
IIV-high dose	65 years and older	0.5 mL	Intramuscular (IM)	Administer vaccine in deltoid muscle.
Adjuvanted inactivated influenza vaccine (aIIV)†	65 years and older	0.5 mL	Intramuscular (IM)	Administer vaccine in deltoid muscle.
Cell culture-based IIV (ccIIV)	All ages	0.5 mL	Intramuscular (IM)	Administer vaccine in deltoid muscle.
Recombinant influenza vaccine (RIV)	18 years and older	0.5 mL	Intramuscular (IM)	Administer vaccine in deltoid muscle.
Live attenuated influenza vaccine (LAIV)	Healthy, younger than age 50 years (except pregnant women)	0.2 mL (0.1 mL into each nostril)	Intranasal spray (NAS)	Spray half of vaccine into each nostril while the patient is in an upright position.

* For complete instructions on how to administer vaccines, see “Clinical Nursing Skills & Techniques by Perry & Potter; additional resource: “How to Administer Intramuscular and Intranasal Influenza Vaccines” at www.immunize.org/catg.d/p2024.pdf

† Given unknown but theoretical concerns of increased reactogenicity when administering two novel adjuvant-containing vaccines (i.e., Fluad, Hecplisav-B, Shingrix) and the availability of nonadjuvanted influenza vaccine options, selection of a nonadjuvanted influenza vaccine may be considered in situations where influenza vaccine and another vaccine containing a Novel adjuvant are to be administered concomitantly. However, vaccination should not be delayed if a specific product is not available.

PNEUMOCOCCAL VACCINE

I. Assess Adults for Need of Vaccination against Streptococcus Pneumoniae (pneumococcus) infection.

A. Routine pneumococcal vaccination:

1. Assess adults age 65 years or older for need of pneumococcal vaccination.
2. Pneumococcal conjugate vaccine (PCV13) should be administered routinely to all previously unvaccinated adults age 65 years or older.
3. Pneumococcal polysaccharide vaccine (PPSV23) is recommended for all adults age 65 years or older
4. Refer to section 5 of this policy for complete details.

B. Risk-based pneumococcal vaccination:

1. Age 19 through 64 years with an underlying medical condition or other risk factor as described in the following table:

CATEGORY OF UNDERLYING MEDICAL CONDITION OR OTHER RISK FACTOR	RECOMMENDED VACCINES ARE MARKED "X" BELOW		
	PCV 13	PPSV23	PPSV23 Booster*
Chronic heart disease ¹ , Chronic lung disease ²		X	
Diabetes mellitus		X	
Chronic liver disease, cirrhosis		X	
Cigarette smoking		X	
Alcoholism		X	
Cochlear implant, cerebrospinal fluid leak	X	X	
Sickle cell disease, other hemoglobinopathy	X	X	X
Congenital or acquired asplenia	X	X	X
Congenital or acquired immunodeficiency ³ , HIV	X	X	X
Chronic renal failure, nephrotic syndrome	X	X	X
Leukemia, lymphoma	X	X	X
Generalized malignancy, Hodgkin	X	X	X

disease			
Iatrogenic immunosuppression ⁴	X	X	X
Solid Organ transplant, multiple myeloma	X	X	X

* A second dose 5 years after the first dose of PPSV23, 1 Excluding hypertension; 2 Including asthma; 3 Including B- (humoral) or T-lymphocyte deficiency, complement deficiencies (particularly C1, C2, C3, and C4 deficiencies), and phagocytic disorders (excluding chronic granulomatous disease); 4 Diseases requiring treatment with immunosuppressive drugs, including long-term systemic corticosteroids and radiation therapy.

II. Screen for Contraindications and Precautions:

A. Contraindications:

1. Do not give pneumococcal vaccine (PCV13 or PPSV23) to a patient who has experienced a serious systemic or anaphylactic reaction to a prior dose of the vaccine or to any of its components.
2. For a list of vaccine components, refer to the manufacturer's package insert.

B. Precautions:

1. Moderate or severe acute illness with or without fever.

III. Provide Vaccine Information Statements:

- A. Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS).
- B. Provide non-English speaking patients with a copy of the VIS in their native language.
- C. Vaccine Information Statements can be found at www.immunize.org/vis.

IV. Prepare to Administer Vaccine:

- A. PCV 13 must be given intramuscularly (IM).
- B. PPSV23 may be administered either IM or subcutaneously
- C. For Vaccine that is to be administered IM, choose the needle gauge, needle length, and injection site according to the following chart:
- D. If you prefer subcutaneous injection of PPSV23, choose a 23-25 gauge, 5/8" needle for injection into the fatty tissue overlying the triceps muscle.

Gender and weight of patient	Needle gauge	Needle length	Injection Site
Female or male less than 130 lbs	22-25	5/8" * - 1"	Deltoid muscle of arm
Female or male 130 – 152 lbs	22-25	1"	Deltoid muscle of arm
Female 153 200 lbs	22-25	1-1 ½"	Deltoid muscle of arm
Male 153 -260 lbs	22-25	1-1 ½"	Deltoid muscle of arm
Female 200+ lbs	22-25	1 ½"	Deltoid muscle of arm
Male 260+ lbs	22-25	1 ½"	Deltoid muscle of

			arm
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* A 5/8" needle may be used in patients weighing less than 130 lbs (<60 kg) for IM injection in the deltoid muscle only if the skin is stretched tight, the subcutaneous tissue is not bunched, and the injection is made at a 90° angle to the skin.

V. Administer PCV13 or PPSV23:

A. Administer PCV13 or PPSV23 0.5ml according to the following dosing information and schedule:

1. PCV 13 must be administered by the IM route
2. PPSV23 may be administered either IM or Subcutaneous

B. Routine Vaccination for all adults ages 65 years and older:

AGE OF PATIENT	VACCINE INDICATED	HISTORY OF PRIOR VACCINATION	SCHEDULE FOR ADMINISTRATION OF PCV13 & PPSV23
65 yrs or older	PPSV23 and 1 time dose of PCV13	None or unknown	Administer PCV13 followed in 1 year* by PPSV23
		PPSV23 when younger than age 65 years; 0 or unknown PCV13	Administer PCV13 at least 1 year after previous PPSV23. Administer another PPSV23 at least 5 years after previous dose of PPSV23 and at least 1 year* after PCV13.
		PPSV23 when younger than age 65 years; PCV13	Administer another PPSV23 at least 5 years after previous dose of PPSV23 and at least 1 year* after previous dose of PCV13.
		PPSV23 when age 65 years or older; 0 or unknown PCV13	Administer PCV13 at least 1 year after PPSV23
		0 or unknown PPSV23; PCV13	Administer PPSV23 at least 1 year* after PCV13.

* For adults age 65 years and older with immunocompromising conditions, functional or anatomic asplenia, cerebrospinal fluid leaks, or cochlear implants, the interval between PCV13 and PPSV23 should be shortened to 8 weeks.

C. Risk-based vaccination for adults ages 19–64 years:

AGE OF PATIENT	VACCINE INDICATED	HISTORY OF PRIOR VACCINATION	SCHEDULE FOR ADMINISTRATION OF PCV13 & PPSV23
19-64 Years	<i>For medical conditions in which only PPSV23 is indicated</i>		
	1 dose of PPSV23	None or unknown	Administer PPSV23
	<i>For medical conditions in which both PCV13 and PPSV23 (1 or 2 doses) are</i>		

<i>recommended</i>		
1 dose PCV13 and 1 dose PPSV23 (i.e. cochlear implant; CSF leak)	None or unknown	Administer PCV13 followed in 8 weeks by PPSV23
	0 or unknown PPSV23; 1 dose PCV13	Administer PPSV23 at least 8 weeks after PCV13
	1 dose PPSV23; 0 or unknown PCV13	Administer PCV13 at least 1 year after PPSV23.
1 dose PCV13 and 2 doses PPSV23 (i.e. immuno- compromised)	None or unknown	Administer PCV13 followed in 8 weeks by PPSV23 #1. Administer PPSV23 #2 at least 5 years after PPSV23 #1.
	1 dose PPSV23; 0 or unknown PCV13	Administer PCV13 at least 1 year after PPSV23 #1. Administer PPSV23 #2 at least 5 years after PPSV23 #1 and at least 8 weeks after PCV13
	0 or unknown PPSV23; 1 dose PCV13	Administer PPSV23 #1 at least 8 weeks after PCV13. Administer PPSV23 #2 at least 5 years after PPSV23 #1
	1 dose PPSV23; 1 dose PCV13	Administer PPSV23 #2 at least 5 years after PPSV23 #1 and at least 8 weeks after PCV13.
	2 doses PPSV23; 0 or unknown PCV13	Administer PCV13 at least 1 year after PPSV23 #2.

DOCUMENTATION OF VACCINES

I. Document Vaccination:

- A. Document each patient's vaccine administration information and follow up in the patient's Medical Record: record the date the vaccine was administered, the manufacturer, lot number, expiration date, the vaccine site and route, publication date of the VIS
- B. Medical records should be retained in accordance with applicable state laws and regulations.
- C. If vaccine was not administered, record the reasons for non-receipt of the vaccine (e.g. medical contraindication, patient refusal).
- D. RN to place influenza and/or pneumococcal vaccine order in PWM for physician to sign off

II. Physician may cancel influenza and pneumococcal vaccine administration:

- A. Physician to document in patient's medical record, influenza and/or pneumococcal vaccine not to be administered to patient.

MEDICAL EMERGENCIES

I. Be Prepared to Manage Medical Emergencies:

- A. Be prepared for management of a medical emergency related to the administration of influenza and pneumococcal vaccine by following emergency protocol within the clinic.

- B. To prevent syncope, vaccinate patients while they are seated or lying down.
- C. Observe patient for 15 minutes after receipt of the vaccine.

ADVERSE EVENTS

- I. Report all Adverse Events to Vaccine Adverse Event Reporting System (VAERS):
 - A. Report all adverse events following the administration of influenza and pneumococcal vaccine to the VAERS. To submit a VAERS report online or to download a PDF form, go to <https://vaers.hhs.gov/reportevent.html>. Further assistance is available at (800) 822-7967.
 - B. Notify Physician immediately of vaccine adverse reaction
 - C. Complete Adverse Drug Reaction Notification using Unusual Occurrence Reporting link found on ARMC Intranet
 - D. Refer to ARMC Department of Pharmacy Services Policy No. 10.1 for complete instructions on reporting and documenting adverse vaccine reactions.

STAFF EDUCATION/COMPETENCY

- I. Staff Education and Competency Requirements:
 - A. RN's are qualified to screen and administer the influenza and pneumococcal vaccine upon successful completion of a post-test upon hire and on an annual basis.
 - B. LVN's are qualified to administer the influenza and pneumococcal vaccine upon successful completion of a post-test upon hire and on an annual basis.
 - C. Post tests are maintained in the employee file and in the Education Development Department

REFERENCES: Clinical Nursing Skills & Techniques by Perry & Potter
<https://www.cdc.gov/flu/professionals/vaccination/index.htm>
<https://www.cdc.gov/vaccines/vpd/pneumo/hcp/index.html>
(2018) Use of Standing Orders Programs to Increase Adult Vaccination Rates.
Retrieved July 29, 2019 from the Center for Disease Control Website:
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr4901a2.htm?c_cid=journalsearch_promotion_2018

DEFINITIONS: N/A

ATTACHMENTS: Influenza/Pneumococcal Vaccine Screening/Consent (English/Spanish)

SUBJECT: ADMINISTERING INFLUENZA & PNEUMOCOCCAL
VACCINES TO ADULTS

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APPROVAL DATE:	<u>N/A</u>	<u>Policy, Procedure and Standards Committee</u>
	<u>7/31/19</u>	<u>Nanette Buenavidez, Interim Chief Nursing Officer</u> Applicable Administrator, Hospital or Medical Committee
	<u>7/31/19</u>	<u>Pharmacy and Therapeutics Committee</u> Applicable Administrator, Hospital or Medical Committee
	<u>8/1/19</u>	<u>Quality Management Committee</u> Applicable Administrator, Hospital or Medical Committee
	<u>8/1/19</u>	<u>Medical Executive Committee</u> Applicable Administrator, Hospital or Medical Committee
	<u>8/20/19</u>	<u>Board of Supervisors</u> Approved by the Governing Body

REPLACES: N/A

EFFECTIVE: 8/20/19

REVISED: 7/31/19

REVIEWED: 7/31/19

ATTACHMENT A

INFLUENZA/PNEUMOCOCCAL VACCINE CONSENT/ORDER

PNEUMOCOCCAL VACCINATION Administer vaccine if ANY of the following boxes are checked: <input type="checkbox"/> I am 65 years or older and have never received the vaccine <input type="checkbox"/> I was vaccinated before the age of 65 and it has been more than 5 years since I received the pneumococcal vaccine <input type="checkbox"/> I am 19 to 64 years of age and smoke or have asthma and have never been vaccinated <input type="checkbox"/> I am immunocompromised (**see below**) and it has been more than 5 years since I received the pneumococcal vaccine <input type="checkbox"/> I am 18 to 64 years of age with any of the following conditions: Immunocompetent persons ____ Heart disease/CHF/HTN ____ Lung disease/COPD ____ Diabetes ____ Alcoholism ____ Liver Disease ____ Cochlear implant ____ Cerebral Spinal Fluid leak **Immunocompromised persons** ____ Kidney failure/ESRD ____ Lymphoma or leukemia ____ Multiple myeloma ____ Nephrotic syndrome ____ Hodgkin's disease ____ HIV infection or AIDS ____ History of solid organ transplant ____ Medication that affects my immune system (Long-term steroid use or radiation/cancer treatment more than 2 weeks ago) ____ Asplenia (sickle cell disease, malposition of the heart, anomalies of the spleen)	INFLUENZA VACCINATION <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <input type="checkbox"/> Influenza vaccine is out of stock at this time <input type="checkbox"/> It is not influenza season (October thru March) </div> If neither of the above choices apply, proceed to the questions below: <input type="checkbox"/> For Females: Are you currently pregnant? If yes, preservative-free inactivated flu vaccine will be given. Administer vaccine only if ALL boxes are checked: <input type="checkbox"/> I am NOT allergic to latex or Thimerosal <input type="checkbox"/> I have not had a serious reaction/problem with the flu vaccine in the past and/or despite my allergies (if any) I want to receive the influenza vaccine <input type="checkbox"/> I am 18 years or older <input type="checkbox"/> I have not received a flu vaccine this influenza season The CDC recommends influenza vaccine even for those with history of any egg allergy. Knowing this fact and risks, I choose to accept the Influenza Vaccine: I release Arrowhead Regional Medical Center, its employees and representatives from any liability or further responsibility with regard to my receiving the vaccine.
EXCLUSION CRITERIA: Do not give pneumococcal vaccine if ANY box is checked below: <input type="checkbox"/> If patient is less than 18 years of age (Physician order required) <input type="checkbox"/> I am pregnant (Reassess the need for pneumococcal vaccination if the baby is delivered during this hospitalization) <input type="checkbox"/> Documentation of: ____ Pneumococcal vaccine given this hospitalization or in the past ____ Bone marrow transplant within the past 12 months ____ Receiving chemotherapy or radiation therapy during this hospitalization or within 2 weeks ____ Received Zostavax (Shingle's vaccine) within the last 4 weeks ____ Patients with an organ transplant during the current hospitalization ____ Allergy/sensitivity to pneumococcal vaccine ____ Patient declined	EXCLUSION CRITERIA: Do not give influenza vaccine if ANY box is checked below: <input type="checkbox"/> If patient is less than 18 years of age (Physician order required) <input type="checkbox"/> Received influenza vaccine during the current hospitalization or flu season <input type="checkbox"/> Allergy/sensitivity to influenza vaccine or anaphylactic allergy to latex or Thimerosal <input type="checkbox"/> Bone marrow transplant within the past 6 months <input type="checkbox"/> History of Guillain-Barré Syndrome within 6 weeks after a previous influenza vaccination <input type="checkbox"/> Patients with an organ transplant during the current hospitalization <input type="checkbox"/> Patient declined
<input type="checkbox"/> Current Pneumococcal Vaccine Information Statement (04/24/15) given to patient/representative. <input type="checkbox"/> Current Influenza Vaccine Information Statement (08/07/15) given to patient/representative.	
SCREENED BY: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> PRINT NAME SIGNATURE TITLE DATE TIME </div>	
CONSENT (Place a checkmark in the box(s) below to indicate the type of vaccine you are giving consent to receive) I choose to accept the: <input type="checkbox"/> Pneumococcal Vaccine <input type="checkbox"/> Influenza (Flu) Vaccine I am signing this consent to verify that I have not had a serious reaction or problem with the vaccine(s) in the past. I have read or had explained to me the information about the vaccine(s) and have had all of my questions answered. I understand the risks and benefits of the vaccine and authorize it to be given to me. <div style="display: flex; justify-content: space-between; font-size: small; margin-top: 10px;"> _____ SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE _____ RELATIONSHIP IF OTHER THAN PATIENT SIGNATURE _____ DATE </div>	
VACCINE(S) NOT GIVEN FOR THE FOLLOWING REASONS: I choose to decline the <input type="checkbox"/> Pneumococcal vaccine <input type="checkbox"/> Influenza (Flu) vaccine <div style="display: flex; justify-content: space-between; font-size: small; margin-top: 10px;"> _____ SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE _____ RELATIONSHIP IF OTHER THAN PATIENT SIGNATURE _____ DATE </div>	

TO OBTAIN VACCINE(S) PLEASE SCAN OR SEND THIS FORM TO THE PHARMACY

PATIENT IDENTIFICATION

ARROWHEAD REGIONAL MEDICAL CENTER

**INFLUENZA/PNEUMOCOCCAL VACCINE
CONSENT/ORDER**



LGLINVAC

ATTACHMENT A INFLUENZA/PNEUMOCOCCAL VACCINE CONSENT/ORDER

<p>LA VACUNA ANTINEUMOCÓCICA Administre la vacuna si es que ALGUNA de las casillas de abajo han sido marcadas:</p> <p><input type="checkbox"/> Tengo 65 años de edad o más y nunca he recibido la vacuna.</p> <p><input type="checkbox"/> He sido vacunado antes de la edad de los 65 años y han pasado más de 5 años desde que recibí la vacuna antineumocócica</p> <p><input type="checkbox"/> Tengo 19 a 64 años de edad y soy fumador o padezco de asma y nunca he sido vacunado</p> <p><input type="checkbox"/> Estoy inmunocomprometido (**mire abajo**) y han pasado 5 años desde que recibí la vacuna antineumocócica</p> <p><input type="checkbox"/> Tengo 18 a 64 años de edad con cualquiera de las siguientes condiciones:</p> <p>Personas Inmunocompetentes</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Enfermedades del Corazón/CHF/HTN</td> <td><input type="checkbox"/> Enfermedad Pulmonar/EPOC</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Alcoholismo</td> </tr> <tr> <td><input type="checkbox"/> Enfermedad del Hígado</td> <td><input type="checkbox"/> Implante Coclear</td> </tr> <tr> <td><input type="checkbox"/> Fuga de Líquido Cefalorraquídeo</td> <td></td> </tr> </table> <p>** Personas Inmunocomprometidas **</p> <p><input type="checkbox"/> Insuficiencia Renal/Nefropatía Terminal (ESRD) Linfoma o Leucemia</p> <p><input type="checkbox"/> El Mieloma Múltiple <input type="checkbox"/> El Síndrome Nefrótico</p> <p><input type="checkbox"/> Enfermedad de Hodgkin <input type="checkbox"/> Infección de VIH o de SIDA</p> <p><input type="checkbox"/> Historial de trasplante de órganos sólidos</p> <p><input type="checkbox"/> Medicamentos que afectan mi sistema inmune (El uso prolongado de esteroides o tratamiento de radiación/cáncer hace más de 2 semanas)</p> <p><input type="checkbox"/> Asplenia (La enfermedad de células falciformes, la mala posición del corazón anormal del bazo)</p>	<input type="checkbox"/> Enfermedades del Corazón/CHF/HTN	<input type="checkbox"/> Enfermedad Pulmonar/EPOC	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Alcoholismo	<input type="checkbox"/> Enfermedad del Hígado	<input type="checkbox"/> Implante Coclear	<input type="checkbox"/> Fuga de Líquido Cefalorraquídeo		<p>VACUNA CONTRA LA INFLUENZA</p> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <input type="checkbox"/> Influenza vaccine is out of stock at this time <input type="checkbox"/> It is not influenza season (October thru March) </div> <p>If neither of the above choices apply, proceed to the questions below:</p> <p><input type="checkbox"/> Para Mujeres: ¿Está embarazada actualmente? En caso afirmativo, se administrará una vacuna antigripal sin conservantes.</p> <p>Administer vaccine only if <u>ALL</u> boxes are checked:</p> <p><input type="checkbox"/> NO soy alérgico a Timerosal o látex</p> <p><input type="checkbox"/> No he tenido una reacción/problema serio con la vacuna contra la gripe en el pasado y/o apesar de mis alergias quiero recibir la vacuna contra la influenza</p> <p><input type="checkbox"/> Tengo 18 años o más</p> <p><input type="checkbox"/> No he recibido una vacuna contra la gripe durante esta temporada de influenza</p> <p>El CDC recomienda la vacuna contra la gripe incluso para aquellos con antecedentes de cualquier alergia al huevo. Conociendo este hecho y los riesgos, el/la paciente acepta la vacuna antigripal: libero a Arrowhead Regional Medical Center; sus empleados y representantes de cualquier responsabilidad o responsabilidad adicional con respecto a mi recepción de la vacuna</p>
<input type="checkbox"/> Enfermedades del Corazón/CHF/HTN	<input type="checkbox"/> Enfermedad Pulmonar/EPOC								
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Alcoholismo								
<input type="checkbox"/> Enfermedad del Hígado	<input type="checkbox"/> Implante Coclear								
<input type="checkbox"/> Fuga de Líquido Cefalorraquídeo									
<p>EXCLUSION CRITERIA: Do not give pneumococcal vaccine if ANY box is checked below:</p> <p><input type="checkbox"/> If patient is less than 18 years of age (Physician order required)</p> <p><input type="checkbox"/> I am pregnant (Reassess the need for pneumococcal vaccination if the baby is delivered during this hospitalization)</p> <p><input type="checkbox"/> Documentation of:</p> <p><input type="checkbox"/> Pneumococcal vaccine given this hospitalization or in the past</p> <p><input type="checkbox"/> Bone marrow transplant within the past 12 months</p> <p><input type="checkbox"/> Receiving chemotherapy or radiation therapy <u>during</u> this hospitalization or within <u>2 weeks</u></p> <p><input type="checkbox"/> Received Zostavax (Shingle's vaccine) within the last 4 weeks</p> <p><input type="checkbox"/> Patients with an organ transplant during the current hospitalization</p> <p><input type="checkbox"/> Allergy/sensitivity to pneumococcal vaccine</p> <p><input type="checkbox"/> Patient declined</p>	<p>EXCLUSION CRITERIA: Do not give influenza vaccine if ANY box is checked below:</p> <p><input type="checkbox"/> If patient is less than 18 years of age (Physician order required)</p> <p><input type="checkbox"/> Received influenza vaccine during the current hospitalization or flu season</p> <p><input type="checkbox"/> Allergy/sensitivity to influenza vaccine or anaphylactic allergy to latex or Thimerosal</p> <p><input type="checkbox"/> Bone marrow transplant within the past 6 months</p> <p><input type="checkbox"/> History of Guillain-Barré Syndrome within 6 weeks after a previous influenza vaccination</p> <p><input type="checkbox"/> Patients with an organ transplant during the current hospitalization</p> <p><input type="checkbox"/> Patient declined</p>								
<p><input type="checkbox"/> Current Pneumococcal Vaccine Information Statement (04/24/15) given to patient/representative.</p> <p><input type="checkbox"/> Current Influenza Vaccine Information Statement (08/07/15) given to patient/representative.</p>									
<p>SCREENED BY: _____</p> <table style="width: 100%; text-align: center;"> <tr> <td>PRINT NAME</td> <td>SIGNATURE</td> <td>TITLE</td> <td>DATE</td> <td>TIME</td> </tr> </table>		PRINT NAME	SIGNATURE	TITLE	DATE	TIME			
PRINT NAME	SIGNATURE	TITLE	DATE	TIME					
<p>CONSENTIMIENTO (Marque con una marca en la casilla(s) de abajo para indicar el tipo de vacuna que usted está dando su consentimiento para recibir). Firmo este consentimiento para comprobar que no soy alérgico al látex o al timerosal, y no he tenido una seria reacción o problema en el pasado con la vacuna. <input type="checkbox"/> Neumocócica o <input type="checkbox"/> la Influenza (Gripe). He leído y me han explicado la información tocante la vacuna y además todas mis preguntas han sido contestadas. Entiendo los beneficios y riesgos de la vacuna y doy mi autorización para que se me vacune.</p>									
<p>FIRMA DEL PACIENTE O DEL REPRESENTANTE AUTORIZADO _____</p>	<p>RELACIÓN SI NO ES EL PACIENTE QUIEN FIRMA _____</p> <p>FECHA _____</p>								
<p>VACUNA(S) NO SE DAN POR LAS SIGUIENTES RAZONES: <input type="checkbox"/> Cualquiera de los criterios de exclusión marcados <input type="checkbox"/> El Paciente se negó</p> <p>Yo decidí rechazar la <input type="checkbox"/> Vacuna Neumocócica <input type="checkbox"/> Vacuna de la Influenza (Gripe)</p>									
<p>FIRMA DEL PACIENTE O DEL REPRESENTANTE AUTORIZADO _____</p>	<p>RELACIÓN SI NO ES EL PACIENTE QUIEN FIRMA _____</p> <p>FECHA _____</p>								

TO OBTAIN VACCINE(S) PLEASE SCAN OR SEND THIS FORM TO THE PHARMACY

PATIENT IDENTIFICATION

ARROWHEAD REGIONAL MEDICAL CENTER

**INFLUENZA/PNEUMOCOCCAL VACCINE
CONSENT/ORDER**



LGLINVAC