ASH Pharmacy Screening and Questionnaire Form

Patient Information

Name:____ Date of Birth:______________________
Street:____
City:______________________________________ State:____________ Zip:_____________________
Patient ID___________________________________ Gender: M or F
Email address: ___________________________________
Phone Number: ___________________________________
Ethnicity: Hispanic or Latino, Non-Hispanic or Latino Unknown
Black or African American, White, Asian, Native American/Hawaiian/Pacific Islander
Primary Care Physician_________________________________Phone: __________________________
Do you want pharmacy to send a copy of your vaccination documents to your PCP? Yes or No

Please answer the following questions, if any question is not clear, please ask the Pharmacist

Are you sick today?	Yes	No	Unknown
Do you have a long-term health problem? Kidney disease, heart disease, diabetes, anemia, lung disease, or asthma			
Do you allergies to medications, latex, food or any components of a vaccine			
Have you received any vaccinations in the last 3 weeks?			
Do you take steroids eg. Prednisone, or any anti-cancer drugs			
Are you pregnant?			

I give permission for the release of any medical or other information with respect to this vaccine to my healthcare provider, Medicaid, Medicare or other third-party payer as needed and request payments to be made on my behalf to ASH Pharmacy.

- I acknowledge that the pharmacist recommends that vaccinated patients should remain at the waiting area for 15 minutes after vaccine is administered
- I acknowledge the receipt of ASH Pharmacy's Notice of Privacy Practices for Protected Health Information
- I certify my receipt of the services covered by this claim and I request that payments be made on my behalf, and I authorize the holder to release medical information about me to any party involved in payment or their agents.
- I agree that if my insurance does not cover the cost of vaccine and administration at the pharmacy, I will be responsible for the payment of the cost of vaccine and its administration.

I have read or have had read to me the Vaccination information Sheet (VIS) regarding the vaccine. That I have had the opportunity to ask questions that were answered to satisfaction and do understand the benefits and risks of vaccines.
I consent to or give consent for the administration of the vaccine(s) and that I fully release and discharge ASH Pharmacy and its officers and employees of any liabilities for illness, injury, loss or damage which may. Result there from.

____ _____________________________
Signature of Patient or Legal Representative Date

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If Signed by Legal Representative, Relationship to Patient