



The Austin Diagnostic Clinic
Influenza Vaccine Consent Form

PATIENT NAME: _____

ACCT #: _____

DATE OF BIRTH: _____

PHYSICIAN: _____

PHONE: _____

INSURANCE: _____

Temperature: _____ (100.4 F or greater should not receive vaccine today)

PLEASE CIRCLE AN ANSWER TO THE QUESTIONS BELOW:

Is the person to be vaccinated sick today?	Yes	No
Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	Yes	No
Has the person to be vaccinated ever had a reaction to influenza vaccine in the past?	Yes	No
Has the person to be vaccinated ever had Guillain-Barre syndrome?	Yes	No
Were you offered or given an Information Statement (VIS) about this vaccine? VIS: influenza Vaccine (8/15/19) 42 U.S>C. 300aa-26	Yes	No

I have read, or have had explained to me, information about the disease and the vaccine listed above, the financial and privacy information listed above. I understand the benefits and risks of the vaccine cited and consent that the vaccine be given to me or the person named above for whom I am authorized to make this request.

Signature of patient or guardian

Date

TO BE COMPLETED BY ADC STAFF

	INJECTION	DOSE	Vaccine CPT code	Administration Code		DESCRIPTION	ICD 10 CODE
ADULT	Influenza (Adult)	0.5ml	90686	90471		Fluzone Quadrivalent Vaccine	Z23
	Influenza (Adult) Recombinant	0.5ml	90682	90471		Flublok Quadrivalent Recombinant Vaccine	Z23
	Influenza (Adult) High Dose	0.7ml	90662	90471		Fluzone High Dose Quadrivalent Vaccine	Z23
PEDIATRICS	INJECTION	DOSE	Vaccine CPT code	Admin Code for up to 18 YO	Admin with Counseling up to 18 YO	DESCRIPTION	CODE
	6 mo-18 years	0.5ml	90686	90471	90460	Fluzone Quadrivalent Vaccine	Z23
SHOTS FOR TOTS	6 month- 18 years			90471- \$14.85		Any flu vaccine under shots for tots program. (Do not bill separate vaccine CPT code)	Z23

Brand (Circle one): GSK Sanofi Seqirus Lot #: _____

Site: Deltoid/Thigh R or L

Administered by: _____ Date: _____