

# IMMUNIZATION REQUEST

## STATE OF NEW MEXICO - ALBQ

### Southwest Pharmacy

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#### PATIENT INFORMATION:

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Sex: M or F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Physician: \_\_\_\_\_

**\*MEDICAID DOES NOT COVER VACCINATIONS THROUGH OUR CLINIC.\***

#### BILLING INFORMATION

CASH  MEDICARE  OTHER

MEDICARE ID #: \_\_\_\_\_

#### PRESCRIPTION INSURANCE CARD

Medco: NMPSIA  Medco: State of NM



ID # \_\_\_\_\_

Circle One: Cardholder Spouse Child

\* Immunizations are offered as a benefit covered under Catalyst Rx or Express Scripts prescription insurance with no co-payment required. These are currently the only two insurances we are able to bill for immunizations.

#### ANSWER QUESTIONS AND SIGN WAIVER:

- |   |        |           |   |   |
|---|--------|-----------|---|---|
| 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) provided for me. 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
<input type="checkbox"/> Influenza (IM)				Flulaval	111772P1	3/31/2011	8/11/2009
<input type="checkbox"/> Hepatitis A (IM)				Havrix	AHAVB402AA	6/4/2011	3/21/2006
<input type="checkbox"/> Hepatitis B (IM)				Engerix	AHBVB834BA	6/17/2011	7/18/2007
<input type="checkbox"/> Hep A/B Combo (IM)				TwinRix	AHABB176BB	4/9/2011	n/a
<input type="checkbox"/> HPV Human Papillomavirus				Gardasil	0819Y	10/10/2011	2/2/2007
<input type="checkbox"/> Meningococcal (IM)				Menactra			8/16/2007
<input type="checkbox"/> Pneumococcal (IM)				Pneumovax	0508Y	11/26/2010	7/29/1997
<input type="checkbox"/> Tet/Diphth/Pertussis (IM)				Adacel	AC52B049BA	12/17/2011	7/12/2006
<input type="checkbox"/> Shingles (SQ)				Zostavax			9/11/2006

Prescribed By: \_\_\_\_\_