CABARRUS HEALTH ALLIANCE

COVID-19 Recipient Vaccination Questionnaire

PERSONAL AND CONTACT INFORMATION (***Please fill out ALL the information below)***

First Name:_____ **Last Name:** _____ **Date of Birth:** ____/____/____
Month Day Year

Maiden Name: _____ **Social Security Number:** __ __ __ - __ __ - __ __ __ __

Email:_____

Street: _____

City:_____ **County:** _____

State:_____ **Zip Code:** _____

Home Phone:_____ **Mobile Phone:** _____

Communication Preference:

- ☐ Email
- ☐ Text Message
- ☐ Both
- ☐ None

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian / Pacific Islander
- ☐ White
- ☐ Decline to answer

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Gender:

- ☐ Male
- ☐ Female
- ☐ Decline to answer

Are you an Essential Frontline Worker (Police, Food Processing, Teachers, etc.)?

☐ Yes ☐ No

If yes, what is the name of your employer? _____

Do you reside or work in a long-term care/assisted living facility?

☐ Yes ☐ No ☐

If yes, what is the name of the facility?_____

Are you a member of a state or federal recognized tribal nation?

☐ Yes ☐ No

If yes, what is the name of the community?_____

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MEDICAL INFORMATION (Please fill out ALL the information below)

First Name:_____ **Last Name:** _____ **Date of Birth:** ____/____/_____
Month Day Year

Review the below list of conditions known to increase risk of severe illness to COVID-19:

- Asthma
- Cancer
- Cerebrovascular Disease
- Chronic Obstructive Pulmonary Disease
- Chronic Kidney Disease
- Cystic Fibrosis
- Hypertension or High Blood Pressure
- Type 1 Diabetes Mellitus
- Type 2 Diabetes
- Immunocompromised from solid organ transplant
- Immunocompromised state (weakened immune system)
- Liver Disease
- Neurologic conditions, such as Dementia
- Obesity
- Overweight (BMI > 25 kg/m2, but < 30 kg/m2)
- Pregnancy
- Pulmonary Fibrosis (having damaged or scarred lung tissues)
- Sickle Cell Disease
- Smoker
- Thalassemia (a type of blood disorder)

How many conditions known to increase risk of severe illness from COVID-19 do you have?

☐ None
☐ 1
☐ 2 or more

INSURANCE INFORMATION (Please fill out the information below)

(Circle all that apply) INSURANCE / MEDICAID / MEDICARE / NONE

Insurance Company Name: _____ Subscriber's ID (Policy Number): _____
Effective Date: _____ Group number: _____
Subscriber's Name (Policy Holder): _____ Subscribers Date of Birth: _____
Policy holder's employer:_____
Claims mailing address: _____ Benefits telephone number: _____

CONSENT

☑ I understand that vaccine supply is very limited and, therefore subject to strict prioritization in accordance with Centers for Disease Control and North Carolina Department of Health and Human Services (NC DHHS) guidelines. With that understanding, **I hereby certify that I meet the criteria associated with one of the current groups approved for vaccination by NC DHHS.**

☑ I certify that I am: (a) at least 18 years of age (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an "applicable Provider"), to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine. I understand that the health data shared within this questionnaire will be used to determine my eligibility for receiving the COVID-19 vaccination and further determine timing of when the vaccine will be made available tome.

☑ I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the risks and benefits of COVID 19 vaccine and request that the COVID19 vaccine be given to me or the person named above for whom I am authorized to make this request. I have been provided access to the Cabarrus Health Alliance Notice of Privacy Practices. I agree for Medicare, Medicaid and/or Insurance, if applicable, to be billed and I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the Cabarrus Health Alliance.

☑ I have been provided access to the Cabarrus Health Alliance Notice of Privacy Practices.

https://www.cabarrushealth.org/DocumentCenter/View/347/Notice-of-Privacy-Practices

_____ _____
Signature of Recipient Date

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Month Day Year

FOR OFFICIAL USE ONLY

**** Required Fields***

***Responsible Organization:** Cabarrus Health Alliance

"Responsible Organization" is the name of the parent organization or health system that originated and is accountable for the content of the record. If an organization has several clinics or facilities, this would be the organization that represents all of the clinics/facilities.

***Administration at Location:** Cabarrus Health Alliance **POD Site:** _____

"Administration at Location" is the name of the physical clinic or facility that reported the vaccination, refusal, or missed appointment. In a small practice setting, this could be the same as the responsible organization.

*Administration Date: _____/____/_____ *Administration Time: _____ __AM _PM
Month Day Year

* Vaccine Expiration Date: _____/____/_____
Month Day Year

* Vaccine Barcode: _____

*Vaccine Type (CVX): _____ *Vaccine Manufacturer (MVX):_____

*Vaccine Product (NDC): _____ *Vaccine Lot Number: _____

*Available Vaccine Inventory:_____

*Vaccine administered on behalf of (Clinician): _____

***Vaccine Administering Site**	***Vaccine Route of Administration**	***Dose Number**
____Left Deltoid (LD)	____Intramuscular (IM)	____First Dose
____Left Arm (LA)	____Subcutaneous (SQ)	____Second Dose
____Left Lower Forearm (LLFA)		
____Right Deltoid (RD)		
____Right Arm (RA)		
____Right Lower Forearm (RLFA)		
____Left Thigh (LT)		
____Left Gluteus Medius (LG)		
____Left Vastus Lateralis (LVL)		
____Right Thigh (RT)		
____Right Gluteus Medius (RG)		
____Right Vastus Lateralis (RVL)		

Notes:

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