COVID-19 Encounter Form

Date of Service: ___5/19/2021___

Site# and Address: ___Loc. 1 3rd Party, St. Mathew Baptist Church_____Provider: ______________________

Patient Name: ____ DOB: _____________

Address: _____________________________ City: ________________ State: _______ Zip Code: _________

Email Address: _________________________ Phone Number: _______________________

Sex: ______Race: ______Ethnicity: ___________

Product Name: COVID 19 Vaccine **Mcf:** Pfizer-BioNTech **Lot#: EW0150**
NDC#: 59267-1000-1 **Exp Date: 7/2021**

Time Vaccine Administered: ________________ Vaccine Administered by (Print Name): _________________

CPT Codes

Covid-19 Vaccination (Pfizer) 91300____
Administration FIRST Dose 0001A____
Administration SECOND Dose 0002A____

Diagnosis Code

Encounter for Immunization Z23____

NOTES:

Patient here today for Covid-19 Vaccine. Patient given vaccine IM in _____arm. Patient tolerated procedure well after waiting 15 minutes.

provider signature and credentials

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name ____________________

Age __________

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product ____________			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of a COVID-19 vaccine including either of the following:			
○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
• A previous dose of COVID-19 vaccine.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Form reviewed by ____________________ **Date** ____________