Bremo PHARMACY
Small Pharmacy... Big Hearts

☐ VIIS updated
☐ Inventory transferred
☐ MD faxed

2020-2021 Screening Form

LAST NAME:		FIRST:		MIDDLE INITIAL:
ADDRESS:		CITY	STATE	ZIP
DATE OF BIRTH:	PHONE:	MOTHERS MAIDEN NAME:	❑ MALE	❑ FEMALE
PRIMARY CARE PHYSICIAN:		DRUG ALLERGIES:		

Which vaccine(s) would you like today? ____ Flu Shot ___ Pneumonia ____**Shingles** ___ Tdap

Age Group: (circle) <18 years 18-49years **50-64years** ≥65 years

HAVE YOU EVER HAD A SEVERE REACTION TO A VACCINE THAT REQUIRED MEDICAL CARE?	YES	NO
DO YOU HAVE AN ALLERGY TO EGGS, LATEX, OR GELATIN?	YES	NO
DO YOU HAVE A FEVER, INFECTION, OR OTHER TEMPORARY ILLNESS TODAY?	YES	NO
Do you have a long-term health condition or a condition that lowers your body's resistance to infection?*** Such as: **(circle)** **Heart disease, lung disease, sickle cell disease, diabetes, asthma, alcoholism, cirrhosis, leaks of cerebral fluid or cochlear implant, Hodgkin's disease, lymphoma or leukemia, kidney failure, multiple myeloma, nephritic syndrome, HIV or AIDS, damaged spleen or no spleen, organ transplant, long term steroid treatment, radiation, neurologic or neuromuscular disease, liver disease, anemia***	**YES***	NO*
ARE YOU A SMOKER?	YES	NO
ARE YOU PREGNANT OR BREASTFEEDING?	YES	NO
HAVE YOU HAD ANY RECENT VACCINATIONS	YES	NO
HAVE YOU RECEIVED THE PNUEMONIA VACCINE BEFORE? If so, list	YES	NO
HAVE YOU RECEIVED THE SHINGLES VACCINE BEFORE? If so, list date:_____Type_____	YES	NO

*****Note- If patient's are immunocompromised, they are indicated to receive the pneumococcal vaccine but are CONTRAindicated to receive the Shingles vaccine**

Richmond Apothecaries, Inc. Pharmacies (Bremo, Bremo LTC, or Henrico Pharmacies), including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or other Health Insurance Payer and its agents any information needed to determine these benefits or benefits for related services. **I recognize that in the event that my insurance does NOT pay, I am responsible for payment.** Please view Richmond Apothecaries privacy statement at www.bremorx.com

We offer insurance billing for Medicare. If you have traditional Medicare, enter ID below.
(If you are in an HMO Medicare plan, please show your ID card to the pharmacist)

Medicare ID #					-				-				

I have read, or had explained to me, the information about the vaccine(s) marked above. I have had the chance to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s) marked above

_____ _____
Signature **Date of vaccination**
(Note: If signed by authorized agent, include "by", name, address, relationship, and reason for signing)

Follow up appointment for:
_____
On or after ___/___/_____

For Internal Use: FLU:

Afluria (QUAD)	LOT: P100245061	EXP: 6/30/21	LA RA
Fluarix (QUAD)	LOT: NY4EK	EXP: 6/30/21	
Fluzone (QUAD)	LOT:	EXP:	
Fluzone HD (QUAD)	LOT:	EXP:	
Fluad (65+) (TRI)	LOT: 279736	EXP: 5/4/21	

Pneumovax 23 (IM): lot/exp:
LA RA
Prevnar 13 (IM): lot/exp:
LA RA
Shingrix (IM): lot/exp:
LA RA
Tdap (IM): lot/exp
LA RA

VIS: Inactivated Influenza Vaccine (8/15/19); Pneumococcal polysaccharide (PPSV23 10/30/19); Pneumococcal Conjugate Vaccine (PCV13 10/30/19); Zoster/Shingles (Recombinant 10/30/19), Tdap (4/1/20)
Cash: _____ Other/GH:_____
Initials: T. Kaefer_____, L. Mascari_____, J. Helmke_____, R. Richardson _____, B.Loehr_____C. Cary_____, D. Fonner_____, S. Hendrick_____, K. Kittinger_____, A. Davis _____, Other_____