Leo Toupin, MD
12335 Hymeadow Drive, Suite 150
Austin, Texas 78750

Patient Name: _____ Date of Birth: _____

Address: _____Phone: _____

Are you on Anticoagulant (Blood Thinners) Therapy?	**____Yes**	**____No**
Anticoagulant Drug Name _____		
Have you had a past reaction to injections?	**____Yes**	**____No**
Are you allergic to eggs?	**____Yes**	**____No**
If applicable, are you pregnant?	**____Yes**	**____No**
Last Menstrual Period _____		
Do you have an active nerve disorder?	**____Yes**	**____No**
Did you receive a vaccine information sheet?	**____Yes**	**____No**

INJECTION	DOSE	SITE	LOT#	EXP
___Fluzone High Dose (65+)	**.5cc**	**___L___R___**	**UI663AB**	**04/2017**
___Flulaval Quad	**.5cc**	**___L___R___**	**7KK33**	**04/2017**
___Hepatitis B (IM) >19	**1.0cc**	**___L___R___**		
___Hepatitis B (IM) <19	**.5cc**	**___L___R___**		
___Hepatitis A (IM)	**.5cc**	**___L___R___**		
___Twin Rx (IM)	**1.0cc**	**___L___R___**		
___MMR (SQ)	**.5cc**	**___L___R___**		
___Meningitis (see insert)	**.5cc**	**___L___R___**		
___Pneumonia (IM)	**.5cc**	**___L___R___**		
___Tetanus/Diphtheria (IM)	**.5cc**	**___L___R___**		
___TDAP (IM)	**.5cc**	**___L___R___**		
___Gardisil (IM)	**.5cc**	**___L___R___**		
___Zostavax (see insert)	**.5cc**	**___L___R___**		

"I have read, had explained to me, or been given a Vaccine Information Statement (VIS) for the Vaccine(s) noted above. I understand the benefits and risk of the vaccine(s) checked, and ask that the vaccine be given to the patient named above for whom I am authorized to make this request."

Your insurance company will only pay for services that it determines to be "Reasonable and Necessary" or a covered benefit. Medicare will only pay for services that it determines to be "Reasonable and Necessary" under section 1862(a) (1) of the Medicare law. Before receiving the following Vaccines we need to make you aware and have you sign that you are aware you may be financially responsible for charges incurred.

Although this wording implies your insurance company may not consider Vaccines medically necessary, I emphasize that in my professional judgment, the service listed above is needed in order to render high quality care to you.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Signature of Nurse Date