

VACCINE CONSULT Today's Date:_____

HMO:_____ ID#:_____

Patient Name:_____

DOB:_____ Patient Age:_____

Vaccines recommended per WIR.

☐ See attachment:

- ☐ Counseled qualifications and risk factors
- ☐ Scheduled next dose
- ☐ Side effects discussed
- ☐ 8-15 mins spent counseling on preventative health

Notes:_____

Preventative Health (Vaccine Consult) completed by pharmacist

Pharmacist Initials



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