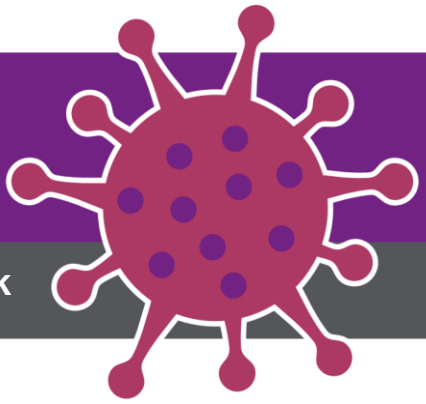
CORONA**VI**RUS **DI**SEASE 2019
(COVID-19)

This document is part of the **COVID-19 Vaccine Operations Guidebook**



Audience: COVID-19 Vaccine Task Force
Revision Date: 5/18/22
Version: #3
COVID-19 Response Team Owner: Legal
Date of Last Review: 5/18/22

PROCESS – Part 1 – Registration, Acknowledgement & Consent Form

What's changed:

- Added history of Guillain-Barré syndrome (GBS) to screening questions
- Added the following paragraph to the acknowledgement section:

I understand the Janssen COVID-19 Vaccine is authorized for use in those 18 years of age and older for whom other authorized or approved COVID-19 vaccines are not accessible or clinically appropriate, and for individuals 18 years of age and older who elect to receive the Janssen COVID-19 Vaccine because they would otherwise not receive a COVID-19 vaccine.

Trinity Health

Johnson & Johnson (Janssen) COVID-19 Vaccine
REGISTRATION, ACKNOWLEDGEMENT & CONSENT FORM

INSTRUCTIONS: **MARCOMM** - 1) Please add specific instructions for your patient based on your specific workflow/ process. 2) Add HM name and change font color as noted below. 3) A HM logo may be added. **Do not delete any fields or info in the form. *Please complete and bring with you to your appointment***

Date: _____

Patient Name (last, first, middle): _____

Birth Date: _____ Sex: □ Male □ Female □ Nonbinary □ Prefer not to answer Marital Status: □ S □ M □ D □ W

Race (select one): □ White □ Black or African American □ American Indian/Alaskan □ Asian □ Unknown □ Native Hawaiian □ Other Pacific Islander □ Decline to answer

Ethnicity (select one): □ Not Hispanic/Latino □ Hispanic/Latino □ Unknown □ Decline to answer

Social Security Number _____ -_____-_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone #: (home/cell)_____ Secondary #: (home/cell)_____+_____

Patient Email Address_____

Emergency Contact (last, first, middle): _____ Relationship: _____

Primary Phone # _____ Secondary Phone # _____

Employer: _____ Occupation: _____

Employer's Phone # _____

Insurance Information

Primary Insurance Co: _____ Effective Date: _____ Policy Number: _____

Group Number: _____ Policyholder's Full Legal Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Sex: □ Male □ Female □ Nonbinary □ Prefer not to answer Birth Date: _____ Social Security ___-___-____

Secondary Insurance Co: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Policyholder's Full Legal Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Sex: □ Male □ Female □ Nonbinary □ Prefer not to answer Birth Date: _____ Social Security ___-___-____

Relationship to Patient: _____ Policyholder's Employer: _____

Patient Name: _____ **Birth Date:** _____

If uninsured, you must check the box below to attest that the following information is true and accurate:

□ I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government funded health benefit plan. In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program, please provide either (a)valid Social Security number, (b)state identification number and state of issuance, OR (c) a drivers license number and state of issuance.

Social Security Number	*or* State Identification Number & State	*or* Driver's License Number & State

SCREENING QUESTIONS

	YES	NO	DON'T KNOW
1. Are you sick today?	◯	◯	◯
2. Do you have allergies to any contents in this vaccine, which includes polysorbate?	◯	◯	◯
3. Have you ever had any allergic reaction (severe or immediate) to any vaccine?	◯	◯	◯
4. Do you have a bleeding disorder or are you on a blood thinner?	◯	◯	◯
5. Are you immunocompromised or on any medications that affect your immune system?	◯	◯	◯
6. Have you received a COVID-19 vaccine previously?	◯	◯	◯
7. **Female patients:**			
a) Are you or could you be pregnant?	◯	◯	◯
b) Are you planning to become pregnant?	◯	◯	◯
c) Are you breastfeeding?	◯	◯	◯
8. In the past two weeks, have you tested positive for COVID-19 or have you currently been exposed to someone with COVID-19? (For healthcare personnel: have you had a high risk exposure for which you have been recommended to quarantine?)	◯	◯	◯
9. If you were diagnosed with COVID-19 in the past 90 days did you receive antibody therapy or convalescent plasma for treatment of your COVID illness?	◯	◯	◯
10. Do you or have you ever had multisystem inflammatory syndrome (MIS), a condition in which body parts become inflamed?	◯	◯	◯
11. Have you had a low blood platelet count caused by heparin-induced thrombocytopenia (HIT)?	◯	◯	◯
12. Do you have a history of Guillain-Barré syndrome (GBS)?	◯	◯	◯

ACKNOWLEDGEMENT

I was provided the Fact Sheet for Recipients for the COVID-19 vaccine I am receiving. I read and/or had explained to me the information provided about the vaccine.

I understand that blood clots involving blood vessels in the brain, abdomen, and legs along with low levels of platelets (blood cells that help your body stop bleeding), have occurred in some people who have received the Janssen COVID-19 Vaccine. In people who developed these blood clots and low levels of platelets, symptoms began approximately one to two-weeks following vaccination. Most people who developed these blood clots and low levels of platelets were females ages 18 through 49 years. Even though the chance of having this occur is remote, you should seek medical attention right away if you have any of the following symptoms after receiving Janssen COVID-19 Vaccine:

- Shortness of breath,
- Chest pain,
- Leg swelling,
- Persistent abdominal pain,
- Severe or persistent headaches or blurred vision,
  Easy bruising or tiny blood spots under the skin beyond the site of the injection

I understand the Janssen COVID-19 Vaccine is authorized for use in those 18 years of age and older for whom other authorized or approved COVID-19 vaccines are not accessible or clinically appropriate, and for individuals 18 years of age and older who elect to receive the Janssen COVID-19 Vaccine because they would otherwise not receive a COVID-19 vaccine.

I was given the chance to ask questions and any questions I had were answered to my satisfaction. I understand the risks and benefits of the vaccination and I am voluntarily choosing to get the vaccination.

I understand I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. If I have had a previous severe reaction to a vaccine, I will be monitored for 30 minutes. I understand if I experience any side effects after leaving the vaccination area, I should call my doctor, or if the side effects are severe, I should call 911.

Patient Name: _____ **Birth Date:** _____

AUTHORIZATION

I authorize release of my personal, billing and medical information to third party payers, insurance companies or review agencies for use in connection with payment, including eligibility for payment, regulatory or accreditation compliance or as is required for provider to receive payment or reimbursement for care. I authorize and irrevocably assign to the administrator of the vaccine payment of any benefits payable to me/amounts payable for the vaccine I receive.

DISCLOSURE OF RECORDS

I understand [insert name of ministry] may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated by [insert ministry], my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state/federal registries, for purposes of treatment, payment or other health care operations. I also understand that [insert Ministry] will use and disclose my health information as set forth in the ministry Notice of Privacy Practices (a copy is available upon request).

I agree that [insert ministry] and its business associates may contact me by any phone number provided by me or associated with my health record, including cell phone numbers, which could result in charges to me. [insert ministry name] also may contact me by sending text messages or emails, using the contact information I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device.

Patient Name: _____ **Birth Date:** _____

Signature of Patient: _____ **Date:** _____

Signature of Parent or Guardian: _____**Date:** _____