PITTSBURGH MERCY
A HERITAGE OF HOPE

Trinity Health

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

INSTRUCTIONS: ***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

Home Address: _____

City: _____ State: _____ Zip Code: _____

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

Patient Email Address_____

Employer: _____ Occupation: _____

Employer's Phone # _____

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

Primary Phone # _____ Secondary Phone # _____

PCP Name: _____ PCP Address: _____ PCP Phone # _____

SCREENING QUESTIONS

	YES	NO	DON'T KNOW
1. Are you at least 18 years or older?	○	○	○
2. Are you sick today?	○	○	○
3. Do you have allergies to any contents in this vaccine, which includes polysorbate?	○	○	○
4. Have you ever had any allergic reaction (severe or immediate) to any vaccine?	○	○	○
5. Do you have a bleeding disorder or are you on a blood thinner?	○	○	○
6. Are you immunocompromised or on any medications that affect your immune system?	○	○	○
7. Have you received a COVID-19 vaccine previously?	○	○	○
8. **Female patients:**			
a) Are you or could you be pregnant?	○	○	○
b) Are you planning to become pregnant?	○	○	○
c) Are you breastfeeding?	○	○	○
9. 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?)	○	○	○
10. 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?	○	○	○
11. Have you had any vaccinations in the past 14 days?	○	○	○

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 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 Pittsburgh Mercy 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 Pittsburgh Mercy, 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 Pittsburgh Mercy 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 Pittsburgh Mercy 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. Pittsburgh Mercy also may contact me by sending text messages or emails, using the contact information I provide. Methods of contact may include using prerecorded/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:** _____

Immunization Received (to be completed by pharmacist)

Informed Consent Provided	Yes
Injection Administered and Dose	Johnson and Johnson COVID-19 Vaccine 0.5 ml
Date of Injection/Date provided with EUA	
Site of Administration	
Injection Manufacturer	Johnson and Johnson (Janssen)
Injection Lot	
Injection Expiration Date	
Injection Administered By	
EAU Date	January 11, 2022
If applicable, nature of adverse reaction and name of PCP notified	