Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Member Calling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Perform remote screening (e.g. phone) of the patient to minimize risk to the pharmacist and pharmacy technicians prior to scheduling an immunization appointment.*

Discussed with provider and patient indicating compelling need for immunization outweighs risk of transmission of COVID-19 and discussed current CDC recommendations to postpone immunizations:

Date: Time:

Patient Questionnaire:

1. Have you or a family member travelled internationally in the past 14 days or been in contact with anyone who has?
   * Yes
   * No
2. Have you had fever, cough or shortness of breath AND been in close contact with a laboratory confirmed coronavirus patient?
   * Yes
   * No
3. Have you had a fever, cough or shortness of breath AND travelled to a designated high-risk state, China, Hong Kong, Iran, Italy, Japan or South Korea?
   * Yes
   * No
4. Have you had any of the following symptoms in the last 14days: fever, cough, shortness of breath, difficulty breathing, chills?
   * Yes
   * No

*\*If the patient answers yes to any of the above questions consider deferring the immunization.*