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Aloha CMA and CCFFH Operators,
The information contained in this official newsletter has been reviewed and approved by DOH/OHCA. It is being distributed to all CMAs and CCFFHs.

Newsletter # 106 October 29, 2021

Aloha:

Update October 26, 2021 for Adult Residential Care Homes (ARCH), Expanded ARCHs, Community Care Foster Family Homes (CCFFH), and Developmental Disabilities Domiciliary Homes (DDDh).

The purpose of this letter is to provide an update on COVID-19 booster vaccinations for the populations listed above. In January and February 2021, a team of local pharmacies provided in-home vaccinations with Moderna and the same group of local pharmacies are in the process of planning for the in-home Moderna booster vaccination for licensed or certified care homes on Oahu and the Big Island. They will also be offering the influenza vaccine during these home vaccinations. In general, it will be the same pharmacies reaching out to the same homes to schedule the booster and flu vaccinations. Maui and Kauai vaccinations will be led by separate teams from the islands respective District Health Office.

In-home vaccination will be available to all residents of licensed or certified care homes residents as well as any care givers and qualified non-client adults residing at the homes. We are starting the in-home vaccinations the first week of November 1 and will continue until all homes have been offered vaccination.

Attached is an Influenza vaccine consent form along with a COVID-19 vaccine consent form and a COVID-19 booster Emergency Use Authorization (EUA) fact sheet. For residents who are under the Office of Public Guardian (OPG), care home operators do not need to obtain consent from OPG, as MedQuest are working with OPG on the consent, and the OPG consents will be sent to your home email when completed.

Pharmacies have already started contacting homes to begin to schedule booster doses for residents and care givers. If your home has not been contacted yet, please be patient and await a call from the pharmacy.

To print the following forms, please use the link above each image
https://mcusercontent.com/bb0d398cc73da4ae928de08db/images/5cc43e38-f315-e8cc-0a7b-e3ff517e8777.jpg

COVID-19 Vaccination Consent and Release

Salutation (None, Mr., Ms. Mrs., Dr., Prof.)	Last Name	First Name	M.I.
Gender (Female, Male, Decline to Specify, Other)	Date of Birth	Phone Number	E-mail
Street Address	City	State	ZIP code

Ethnicity (circle one):	Hispanic or Latino	Not Hispanic or Latino	Unknown/Not Reported
Race (circle one):	American Indian or Alaska Native	Asian Indian	Chinese
	Filipino	Japanese	Korean
	Vietnamese	Other Asian	Black or African American
	Pacific Islander	Native Hawaiian	Guamanian or Chamorro
	Samoan	Other Pacific Islander	White
	Other	Unknown/Not Reported	Decline to specify

Primary Insurance	Insurance ID	Name of Primary Care Provider

_____Yes (please initial) Consent for Service

I verify that I have been provided with and have read (or had read to me) (1) the Fact Sheet for Recipients and Caregivers for the Emergency Use Authorization (EUA) of the COVID-19 vaccine ("Vaccine"); (2) this COVID-19 Vaccination Consent and Release Form; and (3) any additional information provided to me concerning COVID-19 vaccination. I acknowledge that I have had a chance to ask questions of a healthcare professional about the vaccine. I understand that at this time, some COVID-19 vaccines require 2 doses given 21-28 days apart dependent on the manufacturer. If this is my first dose of the COVID-19 vaccine and a second dose is required, I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the series. I understand the known risks and the potential benefits of receiving the vaccine, and I understand there may be risks to the Vaccine that are not known at this time. I understand that the FDA has authorized use of the vaccine under an Emergency Use Authorization (EUA). I understand Comirnaty is an FDA approved COVID-19 vaccine for those 16 years and older. I request and consent to the vaccine being given to me.

_____ Yes (please initial) Limitation of Liability

I understand that, the CPESN Hawaii Pharmacy, its divisions and affiliates and their respective officers, directors, employees, agents and representatives are immune from civil liability under federal and state law for all claims for loss related to any known or unknown side effects and/or injuries, including but not limited to death, that I, or the person for whom I am authorized to make this request, may experience from this vaccine. This immunity means that if I file a lawsuit against the CPESN Hawaii Pharmacy, the court must dismiss any such lawsuit, and the only exception to this immunity is for claims for willful misconduct.

_____ Yes (please initial) Authorization to Release Information for Medical Treatment and/or Payment

I understand that I am giving the CPESN Hawaii Pharmacy permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or insurance company, as applicable, to enable The CPESN Hawaii Pharmacy to process my insurance claims with respect to the vaccination.

Recipient/Parent/Legal Guardian/POA Name (Please Print)

Signature of Recipient/Parent/Legal Guardian/POA

Date

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Patient's Name: _____ Date of Birth: _____

Prevaccination Checklist for COVID-19 Vaccines

PATIENT QUESTIONS	Yes	No
1. **Are you feeling sick today?**		
2. **Have you ever received a dose of COVID-19 Vaccine?**		
• **If yes, which vaccine product did you receive?** o Vaccine manufacturer: Pfizer _____ Moderna_____ Janssen Johnson & Johnson _____ o Date of First Dose: _____ o Date of Second Dose: _____ o Did you bring your vaccination record card or other documentation? (Yes / No)		
3. **Have you ever had an allergic reaction to:** (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)		
• **A component of a COVID-19 vaccine including either of the following:**	**Yes**	**No**
• Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures		
• Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.		
• **A previous dose of COVID-19 Vaccine?**		
4. **Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?** • (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)		
5. **Check all that apply to you:**		
	Am a female between ages 18 and 49 years old	
	Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies	
	Had COVID-19 and was treated with monoclonal antibodies or convalescent serum	
	Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection	
	Have a weakened immune system (I.e., HIV infection or cancer)	
	Take immunosuppressive drugs or therapies	
	Have a bleeding disorder	
	Take a blood thinner	
	Have a history of heparin-induced thrombocytopenia (HIT)	
	Am currently pregnant or breastfeeding	
	Have received dermal fillers	

Form Reviewed by:

_____ _____

Vaccine Documentation (Pharmacy Use ONLY)

Vaccine	Dose in Series	Date/Time Administered	Route/Site	Manufacturer	Dose	Lot No.	Exp Date	Name of Vaccine Administrator
COVID-19			IM L/R Deltoid					

Faxed _____ Eligibility _____ Billed _____ Checked _____ VAMS _____

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PATIENT INFORMATION

FIRST NAME: _____ M.I. _____ LAST NAME: _____ DATE OF BIRTH: _____

AGE: _____ GENDER: _____ EMAIL: _____ PHONE: _____

PERMANENT MAILING ADDRESS (PLEASE INCLUDE APT, SUITE, OR UNIT #):

_____ CITY: _____ STATE: _____ ZIP: _____

DO YOU HAVE A Primary Care Physician? ☐ YES: _____

☐ NO ☐ CHOOSE NOT TO DISCLOSE

_____ (initial) **I agree to the release of the following information should it be contained in my medical record: Influenza Vaccine Record**

_____ (initial) **I request this record be sent to my primary care physician.**

BILLING INFORMATION

PRIMARY INSURANCE: INSURANCE COMPANY: _____ POLICY ID#: _____

POLICY HOLDER NAME: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDER DOB: _____ SSN: _____

CONSENT FOR INFLUENZA VACCINE

1. **CONSENT FOR TREATMENT:** I wish to receive Influenza Vaccine from a CPESN Hawaii Pharmacy. I acknowledge that the staff has not made any guarantees to me as to the results of treatments. We are billing this to insurance and you will be billed if it is not covered. You agree to payment in full for any balance not covered by your insurance.
2. **FINANCIAL AGREEMENT:** I understand and agree to pay all charges for services rendered in accordance with the regular rates and terms of the CPESN Hawaii Pharmacy. The CPESN Hawaii Pharmacy reserves the right to charge a Late Payment Fee, Returned Check Fee, and/or Credit Card Chargeback Fee. If I choose to pay all charges myself, I will notify this pharmacy prior to receiving services. Should the account be referred to an attorney or collection agency for collections, I agree to pay any reasonable attorney's fees, collection expenses and interest at the statutory rate on all delinquent accounts, whether or not the account is referred to a collection agency. I understand if this service is not covered by my insurance, I will be mailed one (1) statement from Queen's POB Pharmacies for any balance assigned to patient responsibility and that my credit card saved on file will be debited for the balance five (5) days after the date of this statement, if I have one on file.
3. **PATIENT'S RIGHTS AND RESPONSIBILITIES:** My signature below confirms that I have received the information on my Rights and Responsibilities as a patient.
4. **NOTICE OF PRIVACY PRACTICES:** I have reviewed a copy of this facility's Notice of Privacy Practices.

I have read this consent and I am the patient, or the patient's duly authorized representative. On my own behalf, or on the behalf of the patient, I accept and agree to be bound by all of these terms and conditions of services until I revoke this authorization to Queen's POB Pharmacies in writing or until one year since last date of service.

Signature: _____ Date: _____

Parent/Legal Guardian Name: _____ Relationship to Pt: _____

A pharmacy staff member may also review the above questions with you. These answers are true to the best of my knowledge. I have been offered a copy of the VIS form for the Influenza Inactive Vaccine for 2021-2022. I understand the benefits and risks of this vaccination and agree to accept the vaccination. I understand that I may check-in and be given the opportunity to speak to a provider with any questions or concerns that I have regarding the vaccination or contraindications.

RPH USE ONLY: MANUFACTURER: _____ NDC#: _____ LOT #: _____ EXP DATE: _____

INJECTION SITE: L / R DELTOID **PT TOLERATED**: YES / NO **DOSE VOLUME**: 0.5ML / 0.7ML

RX# _____ RPh: _____ DATE: _____

"FLU SHOT" INFLUENZA VACCINE

2021-2022 SEASON

Yearly vaccination is the best protection against influenza. It takes up to 2 weeks for protection to develop. CDC recommendations and the Vaccine Information Statement-Inactivated Influenza Vaccine can be found at this website: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.html

NAME: _____ **DATE OF BIRTH:** _____

Screening Questionnaire for Contraindications to Influenza Vaccination	**Yes**	**No**	**Don't know**
1. Do you feel sick today? If you are not feeling well, the CDC suggests waiting until you feel better	☐	☐	☐
2. Do you have an allergy to a component of the vaccine or an egg allergy?	☐	☐	☐
3. Have you ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Have you ever had Guillain-Barré syndrome? (an autoimmune nerve disorder also called GBS, causing a severe paralyzing illness)	☐	☐	☐

Screening Questionnaire for COVID-19	**Yes**	**No**	**Don't know**
1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?	☐	☐	☐
2. In the past 2 weeks, have you had contact with someone who tested positive for COVID-19?	☐	☐	☐
3. Do you currently or have you in the past 14 days, experienced a new onset of a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?	☐	☐	☐

*** **NOTE: If any answers are yes, you cannot receive a flu vaccine.** ***

_____ _____

Signature Date

TO BE FILLED OUT BY SCREENER:

Patient Temperature: _____ Date:_____

Screener Name_____ Screener Signature_____