Official Patient Referral Form

to Local Health Department for Vaccination

The patient named here:

(Full Name)_____ Date of Birth (_____/_____/_____)

is indicated for one or more vaccinations, has some form of private health insurance and is not eligible for Vaccines for Children (VFC) vaccine in a private provider's office.

Therefore, we are referring this patient to the Local Health Department for currently indicated vaccinations because:

_____The patient is **fully insured** for vaccines but this office does not purchase or maintain a supply of vaccines for patients with insurance

____The patient has insurance which does not cover the cost of any or some vaccines **(underinsured)**

____This office cannot provide an appointment to the patient for required vaccinations before the start of the school year

Physician: please use this space to specify additions or omissions to "currently indicated" vaccinations as determined in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP)

_____

_____

Check one of the following:

_____A copy of this patient's immunization record is attached

_____I attest that the immunization record for this patient in WVSIIS is accurate and current

Name of Office Representative:_____Title: _____

Name of Practice/Clinic:_____ Phone: _____

Signature:_____Date:_____

Wheeling-Ohio County Health Department

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH
Division of Immunization Services

Wheeling-Ohio County Health Department
1500 Chapline Street, Suite 106
Wheeling, WV 26003
Main Phone: (304) 234-3683
Fax: (304) 234-6405
www.ohiocountyhealth.com