



Instructions for Completion of the Influenza Vaccination Standing Orders Form - Optional (CDC 57.134)

| Data Field | Instructions for Data Collection |
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| Facility ID | Required. Blank space for facility to place identification information of the facility as indicated or required by the facility. |
| Patient identifiers | Required. Blank space for facility to place patient identification label or stamp as indicated. Minimum information required includes the alphanumeric patient ID (i.e., the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters), gender, and date of birth. |
| DO NOT VACCINATE | Optional. Check one of the choices. |
| Vaccine offered | Required. Check Yes or No. |
| Influenza Subtype | Conditionally required. Check Seasonal or Non-seasonal. |
| Vaccine declined | Required. Check Yes or No. |
| Reason(s) vaccine declined | Conditionally required. If patient declined influenza vaccination, check all that apply in either section A or section B, but not both. If reasons exist in both categories then section A, medical contraindications, takes priority and should be completed. |
| Orders | Required. Check Vaccinate; Do NOT Vaccinate; or Standing Order – no signature required. |
| Physician signature | Conditionally required. Signature of ordering physician is required if standing order policy is not in place and checked. |
| Vaccine administered | Required. Check Yes or No. |
| Date administered | Conditionally required. If vaccine administered, enter date in MM/DD/YYYY format. |
| Type of influenza vaccine administered: Seasonal or Non-seasonal | Conditionally required. If vaccine administered, indicate which specific vaccine of the seasonal or non-seasonal type was given, and whether it was a live attenuated vaccine (LAIV) or inactivated vaccine (TIV) formulation. |
| Manufacturer | Conditionally required. If vaccine administered, enter name of manufacturer. |
| Lot number | Conditionally required. If vaccine administered, enter lot number used. |
| Route of administration | Conditionally required. If vaccine administered, indicate route of administration used. |
| Vaccine information statement (VIS) provided to patient | Optional. If vaccine administered, indicate type and edition date of vaccine information statement provided, if no vaccine information statement was provided (None), or if it is unknown. |
| Vaccinator ID and Title of Person Administering Vaccine | Optional. If vaccine administered, indicate vaccinator identifier. This is an identifier assigned by the facility and may consist of any combination of numbers and/or letters. Indicate the title of the vaccinator (RN, LPN, Nurse Assistant, etc.). |



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| Name | Optional. If vaccine administered, indicate name of vaccinator by last name, first name, middle name or initial. |
| Work Address, City, State, Zip code | Optional. If vaccine administered, indicate work address of vaccinator. Typically, this would be the facility's address. |