



Table 1. Instructions for Completion of the **High Risk Inpatient Influenza Vaccination Monthly Monitoring Form – Method A (CDC 57.130)**

Data Field	Instructions for Data Collection/Entry
Facility ID	The NHSN-assigned facility ID number will be autoentered by the computer.
Vaccination type	Influenza
Month	Required. Record using this format: MM
Year	Required. Record using this format: YYYY
1. Total # of patient admissions	Required. Total number of inpatient admissions during the month being reviewed.
2. Total # of patients meeting high risk criteria for influenza vaccination	Required. Total number of patients meeting high risk criteria during the month being reviewed.
3. Total # of patients previously vaccinated during current influenza season	Optional. Total number previously vaccinated during current influenza season.
4. Total # of patients meeting high risk criteria previously vaccinated during current influenza season	Required. Total number of patients meeting high risk criteria previously vaccinated during current influenza season during period evaluated.
5. Total high risk patients not previously vaccinated during current influenza season (Denominator: Box 2 - Box 4)	Required. Subtract total number in Box 4 from number in Box 2.
6. Patients meeting high risk criteria offered vaccination but declining for reasons other than medical contraindication	Required. Total number of patients meeting high risk criteria offered vaccination but declining for reasons other than medical contraindication.
7. Patients meeting high risk criteria offered vaccination but having medical contraindication	Required. Total number of patients meeting high risk criteria offered vaccination but having medical contraindication.
8. Patients meeting high risk criteria receiving vaccination during admission	Required. Total number of patients meeting high risk criteria who receive influenza vaccination during their admission.
9. Total patients offered vaccination for high risk criteria	Required. Total of boxes 6, 7 and 8.



Data Field	Instructions for Data Collection/Entry
Label and Data Fields:	Optional. Up to five label and five corresponding custom data fields are available for local use and the values entered. These fields may be analyzed.



Table 2. Instructions for Completion of the **High Risk Inpatient Influenza Vaccination Monthly Monitoring Form – Method B** (CDC 57.132)

Data Field	Instructions for Data Collection/Entry
Facility ID	The NHSN-assigned facility ID number will be autoentered by the computer.
Vaccination type	Influenza
Month	Required. Record using this format: MM
Year	Required. Record using this format: YYYY
1. Total # of patient Admissions	Required. Total number of inpatient admissions of greater than 24 hours during the month being reviewed.
2. Total # of patients previously vaccinated during current influenza season	Optional. Total number previously vaccinated during current influenza season.
3. Total # of patients meeting high risk criteria previously vaccinated during current influenza season	Required. Total number meeting high risk criteria that were previously vaccinated during current influenza season.
Label and Data Fields:	Optional. Up to five label and five corresponding custom data fields are available for local use and the values entered. These fields may be analyzed.



Table 3. Instructions for Completion of the **High Risk Inpatient Influenza Vaccination Method B Form – Part 1** (CDC 57.133)

Data Field	Instructions for Data Collection/Entry
Facility ID	The NHSN-assigned facility ID number will be autoentered by the computer.
Event #	Event ID number will be autoentered by the computer.
Patient ID	Required. Enter the alphanumeric patient ID number. This is the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters.
Social Security #	Optional. Enter the 9-digit numeric patient Social Security Number.
Secondary ID	Optional. Enter the alphanumeric ID number assigned by the facility.
Patient Name	Optional. Enter the last, first, and middle name of the patient.
Gender	Required. Circle F (Female) or M (Male) to indicate the gender of the patient.
Date of Birth	Required. Record the date of the patient birth using this format: M/DD/YYYY.
Ethnicity	Optional. Indicate the patient’s ethnicity: Hispanic or Latino Not Hispanic or Not Latino
Race	Optional. Indicate the patient’s race (all that apply): American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander White
Event Type	FLUVX
Vaccination type	Influenza
Date of Admission	Required. Record the date of the patient admission using this format: MM/DD/YYYY.
High Risk Criteria	Required. Check all high risk criteria that apply.
Vaccine Offered	Required. Check Yes or No. If Yes proceed to HRIIV Method B Form – Part 2, CDC 57.131.



Data Field	Instructions for Data Collection/Entry
Custom Fields and Labels	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields may be customized for local use. NOTE: Each custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter comments about this vaccination. These fields can not be analyzed.
Table 1 - ICD9 codes potentially associated with high risk disease conditions	Conditionally required. If patient has any diagnosis or history of any procedure associated with ICD-9 codes listed in Table 1 check all that apply



Table 4. Instructions for Completion of the **High Risk Inpatient Influenza Vaccination Method B Form – Part 2** (CDC 57.131)

Data Field	Instructions for Data Collection/Entry
Facility ID	The NHSN-assigned facility ID number will be autoentered by the computer.
Event #	Event ID number will be autoentered by the computer
Patient ID	Required. Enter the alphanumeric patient ID number. This is the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters.
Social Security #	Optional. Enter the 9-digit numeric patient Social Security Number.
Secondary ID	Optional. Enter the alphanumeric ID number assigned by the facility.
Patient Name	Optional. Enter the last, first, and middle name of the patient.
Gender	Required. Circle F (Female) or M (Male) to indicate the gender of the patient.
Date of Birth	Required. Record the date of the patient birth using this format: MM/DD/YYYY
Ethnicity	Optional. Indicate the patient’s ethnicity: Hispanic or Latino Not Hispanic or Not Latino
Race	Optional. Indicate the patient’s race (all that apply): American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander White
Event Type	FLUVX
Vaccination type	Influenza
Vaccine offered	Required. Check Yes or No
Vaccine Declined	Required. Check Yes or No
Reason(s) Vaccine declined A. Medical Contraindication	Conditionally Required. If patient declined influenza vaccination, Check all that apply in either section A or section B but not both. If



Data Field	Instructions for Data Collection/Entry
B. Personal reason(s) for declining	reasons exist in both categories then section A, medical contraindications, takes priority and should be completed.
Vaccine Administered	Required. Check Yes or No
Date Vaccine Administered	Conditionally required. If vaccine administered indicate date given using this format: MM/DD/YYYY
Type of influenza vaccine administered	Conditionally required. If vaccine administered, indicate name of vaccine and either Live attenuated vaccine or inactivated vaccine.
Manufacturer	Conditionally required. If vaccine administered, influenza vaccine manufacturer will be autoentered by computer when vaccine type is selected.
Lot Number	Conditionally required. If vaccine administered, enter the lot number of the vaccine given to the patient.
Route of administration	Conditionally required. If vaccine is administered, indicate the route of administration used.
Vaccine Information Statement Provided	Conditionally required. If vaccine is administered, indicate what type of information statement was provided, if any, and the edition date using this format: MM/DD/YYYY
Person Administering Vaccine: Vaccinator ID	Optional. If vaccine is administered, indicate vaccinator identifier. This is the vacinator identifier assigned by the hospital and may consist of any combination of numbers and/or letters.
Person Administering Vaccine: Title	Optional. If vaccine is given indicate title of person administering vaccine (RN, LPN, Nurses Assistant, etc.).
Person Administering Vaccine: Name	Optional. If vaccine is given indicate name of vaccinator by last name, first name, middle name or intial
Person Administering Vaccine: Work Address	Optional. If vaccine is given indicate address of location where vaccine was given. This should be the hospital address in most cases.
Custom Fields and Labels	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields may be customized for local use. NOTE: Each custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter comments about this vaccination. These fields can not be analyzed.



Table 5. Instructions for Completion of the **High Risk Inpatient Influenza Vaccination Standing Orders Form - Optional** (CDC 57.134)

Data Field	Instructions for Data Collection/Entry
Facility ID	Required. Blank space for facility to place identification information of the facility as indicated or required by the facility.
Patient ID	Required. Blank space for facility to place patient identification label or stamp as indicated. Minimum information required includes the alphanumeric patient ID number (This is the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters), gender and date of birth.
High Risk Inclusion Criteria	Required. Check all that apply.
Prior influenza vaccination during current influenza season (OCT – MAR) by documentation or history	Required. Check Yes or No
Vaccine offered	Required. Check Yes or No
Vaccine declined	Required. Check Yes or No
Reason(s) vaccine declined	Conditionally required. 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 Immunize or DO NOT Immunize.
Standing order	Optional. Check if hospital policy provides for standing immunization order.
Physicians signature	Conditionally required. Signature of ordering physician if standing order policy is not in place and checked.
Vaccine administered	Required. Check Yes or No
Type of influenza vaccine administered	Conditionally required. If vaccine administered indicate type of vaccine administered, manufacturer and lot number.
Route of administration	Conditionally required. If vaccine administered indicate route used.
Vaccine Information Statement Provided to Patient	Conditionally required. If vaccine administered indicate type and edition date of vaccine information statement provided, if no vaccine information statement was provided or if it is unknown.
Vaccinator ID of Person Administering Vaccine	Conditionally required. If vaccine administered indicate ID number of person administering the vaccine. This could be the employee number of the vaccinator or a vaccinator ID assigned by the hospital and may consist of any combination of numbers and/or letters.



Data Field	Instructions for Data Collection/Entry
Name	Conditionally required. If vaccine administered indicate name of person administering the vaccine using last name first, followed by first and middle name.
Work Address, city, state, zip code	Conditionally required. If vaccine administered indicate work address of person administering the vaccine. Typically this would be the same as the hospital facility.
Table 1 - ICD9 codes potentially associated with high risk disease conditions	Conditionally required. If patient has any diagnosis or history of any procedure associated with ICD-9 codes listed in Table 1 check all that apply.