

CHRONOLOGICAL RECORD OF MEDICAL CARE
Smallpox Vaccination Initial Note Page 2 (3-Page Format)

9965

This page to be completed by health care provider

Vaccinee number (optional for QA)

1. Provider Assessment Date (MM/DD/YYYY)

□□ / □□ / □□□□

□□□□

3. Vaccine Risk Factors based on page 1 review and interview
(Check all that apply):

2. Reason for Vaccination (Indicate One):

- Pre-outbreak: disease prevention
- Post-outbreak: not exposed to virus
- Post-outbreak: exposed to virus
- Other reason (Describe)

- | | Self | | Close Contact |
|--------------------|-----------------------|-----------------------------|----------------------------------|
| No restriction | <input type="radio"/> | | <input type="radio"/> |
| Pregnancy | <input type="radio"/> | | <input type="radio"/> |
| Immune suppression | <input type="radio"/> | | <input type="radio"/> |
| Skin condition | <input type="radio"/> | | <input type="radio"/> |
| Relevant allergy | <input type="radio"/> | | <input type="radio"/> |
| Heart condition | <input type="radio"/> | 3+ RF <input type="radio"/> | <input type="radio"/> (Describe) |
| Unsure | <input type="radio"/> | | <input type="radio"/> |

4. Comment on any concerns about contraindications, need to defer, need to consult, and/or relevant diagnosis

[Large empty box for comments]

5. Provider Decision and Plan (Check all that apply):

- Vaccinate: Primary (e.g. birth year >1972, military entry >1984)
- Vaccinate: Revaccination
- Medically immune: vaccinated within approp interval (MI)
- Vaccination deferred: Pending consult or lab test
- Vaccination deferred: Temporary contraindication (MT)
- Vaccination contraindicated unless exposed (MP)
- Vaccination not given (other reason specify below):

6. Provider Action, Check all that apply:

- Reason for vaccination decision explained
- Patient understands information given
- Lab test requested
- Consult request written/sent _____
- Follow up appointment planned (Date: _____)
- Other reason (specify below):

Provider Plan and Action Additional Comments (e.g., length of temporary deferrals, what labs/consults requested)

[Large empty box for additional comments]

Provider Signature and Printed Name/Stamp:

[Large empty box for signature and name]

Last Name

□□□□□□□□□□□□□□□□□□

First Name

□□□□□□□□□□

MI

□

Social Security Number

□□□ - □□ - □□□□□□

Patient's Identification (May use mechanical imprint)

- RECORDS MAINTAINED AT:
- RANK/GRADE
- SEX
- DATE OF BIRTH
- SPONSOR NAME
- (or Sponsor SSN)
- RELATIONSHIP TO SPONSOR
- (or FMP)
- ORGANIZATION
- STATUS
- DEPT/SVC



2490

CHRONOLOGICAL RECORD OF MEDICAL CARE Smallpox Vaccination Routine Follow up Note

1. Today's Date (M M / D D / Y Y Y Y)

/ /

2. Smallpox Vaccination Date (MM/DD/YYYY)

/ /

3. Did you put a bandage on the vaccination site? Yes No

3a. IF YES: How many days did you use a bandage?

3b. Did you see the vaccination site every day or two? Yes No

4a. Vaccination site appearance today (Check all that apply)

- local redness
- bump
- reddish blister
- whitish blister
- scab or crust
- local itching
- local rash
- nothing

4b. Vaccinee recall of appearance since vaccination (Check all that apply)

- local redness
- bump
- reddish blister
- whitish blister
- patient did not remember/observe
- scab or crust
- local itching
- local rash
- nothing seen

4c. Check anything else experienced after the smallpox vaccination (Check all that apply)

- headache
- body rash
- itchy all over
- eye infection
- fever (temp in box)
- muscle aches
- feeling lousy
- swollen lymph nodes
- bandage reaction
- other (describe in box)

5. Any problems following vaccination? (Check all that apply)

- Restricted activity How many days?
- Limited duty How many days?
- Missed work How many days?
- Took medication (list in box) How many days?
- Visited clinic or emergency room
- Hospitalized
- Other (describe in box)

6. Note any other reactions, problems or medications following vaccination:

7. Do you believe anyone might have become ill as a result of your immunization? Yes No Unsure

If YES or UNSURE, describe in box (or on continuation page)

8. Provider evaluation and action (check all that apply):

- Fully Immunized ("major reaction," "take")
- Equivocal response
- No response
- Re-vaccination indicated
- Follow-up for events described
- Medication prescribed (list)
- Consultation (Allergy/Immunology/Dermatology/other _____)
- No further follow up planned
- Other action (describe in box) Report to VAERS if warranted.

Provider Notes:

Provider Signature and Printed Name/Stamp:

Last Name

First Name

MI

Social Security Number

- -

Patient's Identification (May use mechanical imprint)

RECORDS MAINTAINED AT:
RANK/GRADE
SEX
DATE OF BIRTH
SPONSOR NAME
(or Sponsor SSN)
RELATIONSHIP TO SPONSOR
(or FMP)
ORGANIZATION
STATUS
DEPART./SER