

**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 WVSIS is accurate and current

Name of Office Representative: \_\_\_\_\_ Title: \_\_\_\_\_

Name of Practice/Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_