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: ____________________________

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

OPRF0716