

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**)

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: _____

