New York State Department of Health (NYSDOH)
Medical Countermeasure (MCM) Clinical Operations (ClinOps)
Point of Dispensing (POD) Operations Job Aid – CDMS Vaccine Screening – Pfizer - Additional Dose

NYSDOH COVID-19 Vaccine Pfizer Additional (Third) Dose

* = Required Field **NYS COVID Vaccine POD Site:** _____

Recipient Information

***First Name** _____ **MI** ___ ***Last Name** _____

***Address** _____ **Apt #** _____

***City** _____ ***State** _____ ***ZIP** _____ ***County** _____

Email Address _____

***Date of Birth (mm/dd/yyyy)** ___/___/_____ ***Telephone #** (___) _____ **Gender** ☐ M ☐ F ☐ Other

Mother's First Name *(if under 19 only)* _____ **Mother's Maiden (Last) Name** *(if under 19 only)* _____

***Race** ☐ Asian or Pacific Islander ☐ Black ☐ Native American or Alaskan Native ☐ White ☐ Multiracial ☐ Other ☐ Unknown ☐ No Response

***Ethnicity** ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ No Response

Emergency Contact (OPTIONAL) - Required if under 18

First Name _____ **MI** ___ **Last Name** _____

Telephone # (___) _____ **Relationship to Recipient** ☐ Parent ☐ Guardian ☐ Spouse ☐ Sibling ☐ Other Relative ☐ Other

Primary Care Provider (OPTIONAL)

First Name _____ **Last Name** _____

City _____ **State** _____ **ZIP** _____ **Telephone #** (___) _____

***Insurance** ☐ Yes ☐ Yes - Not on Me ☐ No ***Type of Insurance** ☐ Commercial ☐ Medicare ☐ Medicaid

***Insurance Name** _____ ***Insurance ID or CIN ID** _____ **Group ID** *(if available)* _____

First Name _____ **Last Name** _____ **Date of Birth** ___/___/_____

Relationship ☐ Self ☐ Parent ☐ Guardian ☐ Spouse/Partner ☐ Sibling ☐ Other

Authorization to Bill ☐ Yes ☐ No

☐ **Check to Acknowledge Notice of Privacy Practices**

Questions for the person receiving Countermeasure (circle the appropriate answer)

Screener Initials: _____

1. Are you currently under the age of 12?	Y	N	Unknown
2. Are you feeling sick today?	Y	N	Unknown
3. In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a health care provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	Y	N	Unknown
4. Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)?	Y	N	Unknown
5. Have you ever had an immediate allergic reaction (e.g. hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injection, or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything?	Y	N	Unknown
6. Are you pregnant or considering becoming pregnant?	Y	N	Unknown
7. Do you have a bleeding disorder, a history of blood clots, or are you currently taking a blood thinner?	Y	N	Unknown
8. Are you moderately or severely immunocompromised due to one or more of the medical conditions or receipt of immunosuppressive medications or treatments listed below?	Y	N	Unknown

1) Active treatment for solid tumor and hematologic malignancies, 2) Receipt of solid-organ transplant and taking immunosuppressive therapy, 3) Receipt of CAR-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy), 4) Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome), 5) Advanced or untreated HIV infection, 6) Active treatment with high-dose corticosteroids (i.e., ≥20mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory

9. Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	Y	N	Unknown
10. Have you received 2 previous doses of the Pfizer or Moderna COVID-19 vaccine and was your last dose at least 28 days ago?	Y	N	Unknown
11. Have you received a previous dose of the Janssen/Johnson & Johnson COVID-19 vaccine?	Y	N	Unknown
12. Have you received a previous dose of a COVID-19 vaccine recognized by the WHO but NOT by the FDA (AstraZeneca – VAXZEVRIA, Sinovac – CORONAVAC, Serum Institute of India – COVISHIELD, Sinopharm)?	Y	N	Unknown
13. NYS COVID Vaccine Certification Form I have read the entire attestation provided in the link above I further agree that by clicking and selecting Yes and submitting this form I am placing the legal equivalent of my handwritten signature on such certification.	Y	N	Unknown

For Staff Use Only

Disposition at Screening: Select one

- ☐ Referred for Countermeasure
- ☐ Referred for Medical Evaluation
- ☐ Countermeasure Declined
- ☐ Other

Disposition at Countermeasure: Select one

- ☐ Countermeasure Provided
- ☐ Referred for Outside Medical
- ☐ Declined
- ☐ Other

Date of Visit (mm/dd/yyyy) ____/____/_____

To be read to the patient, or person authorized to consent for the patient:

1. Did you receive and have an opportunity to review the Fact Sheet for the vaccine?
2. Did you have a chance to ask questions and have them answered to your satisfaction?
3. Do you understand the risks and benefits of the vaccine as described in the Fact Sheet?
4. Do you understand that a second dose is needed for the vaccine to be effective?
5. Do you request the vaccine?

☐ **Check here to indicate that patient answered "Yes" to all questions.**

Countermeasure

Barcode #1

Lot and Expiration #

Administration Site

Left Arm	Left Thigh	Nasal	Left Deltoid	Left Buttock	Other
Right Arm	Right Thigh	Oral	Right Deltoid	Right Buttock	

Total Administered _____ **Total Dispensed** _____

Person Providing Countermeasure

First Name _____

Last Name _____

Provider Professional License # _____

Return Visit Date (mm/dd/yyyy) ____/____/_____

NYSIIS Priority Group (Required, Select One)

Updated 3/23/2021

- ☐ Pregnant
- ☐ HCP Hospital
- ☐ LTCF HCP
- ☐ LTCF Resident
- ☐ HCP Other
- ☐ HCP - Medical Examiner, Coroner
- ☐ EMS
- ☐ Under 50 with underlying health conditions
- ☐ Frontline Public Safety (Fire, Police)
- ☐ HCP Ambulatory
- ☐ Eligible age at time of visit per NYS Guidelines
- ☐ Frontline worker (teacher, public transit, grocery)
- ☐ Public-facing government and public employees
- ☐ Not-for-profit workers who provide public-facing services to New Yorkers in need
- ☐ Essential in-person public-facing building service workers and providers of essential building services

Recipient First Name _____ Last Name _____