Department of Health Care Services (DHCS)

Medical Records
Review Preparation Packet

If you have any questions or need help, please contact our Delegation Oversight Coordinators:

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Department of Health Care Services (DHCS)
Facility Site Review and Medical Records Review

Clinic Policies for Primary Care Provider Settings

Instructions:

All participating provider(s) sites are required to establish safety, member rights and general policies and procedures for their practice. Please review all sample policies and procedures in our educational packet and customize any or all of the policies and their respective attachments you wish to adopt based on your clinic's practice and processes. Please complete the *Approval date*, *Approved by*, *Effective Date*, and *Revision date* for each of the adopted policies. All providers and staff shall receive trainings/in-services on all clinic policies and procedures. Annual trainings/in-services are required for *Blood-Borne Pathogens Exposure Control*, *Biohazardous Waste Management* and *Infection Control/Standard/Universal Precautions*. All clinic policies and evidence of training shall be kept on site or made available upon request.

Medi-Cal Managed Care
Cal MediConnect Plan

Medical Record Review Preparation Checklist

This communication applies to the Medicaid and Medicare-Medicaid Plan (MMP) programs.

Use this Facility Site Review (FSR) and Medical Record Review (MRR) preparation checklist to conduct an internal review of your practice to determine readiness for your upcoming FSR and/or MRR survey. You may reference the most current *California Department of Health Care Services (DHCS) Site Review and MRR Survey Standards*, the American Academy of Pediatrics (AAP), the U.S. Preventive Services Task Force (USPSTF), and other governing entity website links and health plan resources provided as embedded links (in blue) in the checklist below for more information. Reviewing the standards in the checklist (including directions/instructions, rules, regulation parameters, and/or indicators) prior to the FSR and MRR may improve and expedite the survey experience. Not all standards will be applicable to your location.

All new DHCS criteria are underlined. **All critical element criteria** are ***bolded and italicized***. Critical elements are related to potential adverse effects on patient health or safety and have a weighted score of two points. Each critical element found deficient during a full scope site survey, focused survey or monitoring visit shall be corrected by the provider within 10 business days from the survey date. All other criteria have a weighted score of one point and shall be corrected by the provider within 30 calendar days from the survey report date.

Please mark each criteria as "Yes" if your site complies with the requirement, or as "No" if your site does not comply. For each criteria marked as "No," you are encouraged to begin corrective actions prior to your actual survey. Before or at the start of your site visit, it would be useful for you to contact/inform your reviewer to discuss any non-compliant criteria.

We appreciate your cooperation and partnership in completing a successful review.

Medical Record				
Format		**Yes**	**No**	**Comments:**
1.	Member identification is on each page.			
2.	Individual personal biographical information is documented.			
3.	Emergency contact is identified; minor's primary emergency contact must be			
4.	Medical records on-site are maintained and organized.			
5.	Member's assigned and/or rendering primary care physician (PCP) is identified.			
6.	Primary language and linguistic service needs of non- or limited-English proficient (LEP), or hearing/speech-impaired persons are prominently noted.			
7.	Person or entity providing medical interpretation is identified.			
8.	Signed copy of the Notice of Privacy https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/permitted-uses/index.html			
Documentation		**Yes**	**No**	**Comments:**
1.	Allergies are prominently noted.			
2.	Chronic problems and/or significant conditions are listed.			
3.	Current continuous medications are listed.			
4.	Appropriate consents are present: a. Release of medical records b. Informed consent for invasive procedures			

5.	Advanced Health Care Directive information is offered (reviewed at least every five years)			
6.	All entries are signed, dated and legible.			
7.	Errors are corrected according to legal medical documentation standards.			

Coordination/continuity of Care		**Yes**	**No**	**Comments:**
1.	History of present illness or reason for visit is documented.			
2.	Working diagnoses are consistent with findings.			
3.	Treatment plans are consistent with diagnoses.			
4.	Instruction for follow-up care is documented.			
5.	Unresolved/continuing problems are addressed in subsequent visit(s).			
6.	There is evidence of practitioner review of consult/referral reports and diagnostic test results.			
7.	There is evidence of follow-up of specialty referrals made and results/reports of diagnostic tests, when appropriate.			
8.	Missed primary care appointments and outreach efforts/follow-up contacts are documented.			
Adult Preventive Care		**Yes**	**No**	**Comments:**
1.	Initial Health Assessment (IHA): a. Comprehensive history and physical exam to be completed within 120 days			
2.	Periodic health evaluation according to most current USPSTF guidelines a. Comprehensive history and physical exam completed at age-appropriate frequency			
3.	Abdominal Aneurysm Screening: Assess all patients during well-adult visits past and current tobacco use. Men ages 65 to 75 years who have ever at least 100 cigarettes in their lifetime shall be screened once by ultraonography) https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummFinal/abdominal-aortic-aneurysm-screening			
4.	Alcohol Use Disorder (AUD) Screening and Behavioral Counseling: Assess adults at each well-adult visit for AUD. If at any time the PCP identifies a potential AUD (e.g., patient answered *Yes* on *SHA Adult* Q19 or *SHA Senior* Q23), the provider shall: 1) Use CRAFFT, NIM-ASSIST, AUDIT/C or other validated assessment tools; 2) Offer behavioral counseling; 3) Refer to county program; and 4) Complete one expanded screening tool at least annually. https://pubs.niaaa.nih.gov/publications/arh28-2/78-79.htm			
5.	Breast Cancer Screening: Perform a mammogram for women 50 to 75 years old, every 1 to 2 years. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummary Final/breast-cancer-screening			

Adult Preventive Care		Yes	No	Comments:
6.	Cervical Cancer Screening: The USPSTF recommends screening for cervical cancer every three years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus hrHPV testing alone, or every 5 years with hrHPV testing in combination with cytology co-testing. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummary Final/cervical-cancer-screening			
7.	Colorectal Cancer Screening: Perform on adults 45 to 75 years old. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummary Final/colorectal-cancer-screening			
8.	Depression Screening: Per USPSTF, screen all adults at each well visit regardless of risk factors using PHQ-2, PHQ-9, or other validated screening tools. The SHA is not a valid screening tool. Screening should be implemented at each well visit with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSumm			
9.	Diabetic Screening and Comprehensive Diabetic Care: Adults ages 35 to 70 who are overweight or obese should receive a screen for type II diabetes at each well visit. Glucose abnormalities can be detected by HbA1c or fasting plasma glucose or with an oral glucose tolerance test. Offer refer patients with glucose abnormalities to intensive behavioral counseling interventions to promote a healthful diet and physical activity. Patients with diagnosis of IFG, IGT, or type 2 diabetes should be confirmed; repeat testing the same test on a different day is the preferred method of confirmation. with a diagnosis of diabetes, shall have documented evidence of routine comprehensive diabetic care/screening: retinal exams, podiatry, nephrology https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screen-for-prediabetes-and-type-2-diabetes			
10.	Drug Use Disorder Screening and Behavioral Counseling: Assess all adults at each well visit for drug misuse. If at any time the PCP identifies a potential d use disorder (e.g., patient answered *Yes* on *SHA Adult* Q20 or *SHA Senior* the provider shall: 1) Use CRAFFT, NIM-ASSIST, AUDIT/C or other validated assessment tools; 2) Offer behavioral counseling; 3) Refer to county program; and 4) Complete one expanded screening tool at least annually.			
11.	Dyslipidemia Screening/Statin Use: USPSTF recommends that adults without a history of cardiovascular disease (CVD) (e.g., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all the following criteria are met: a. Ages 40 to 75 years b. One or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); c. A calculated 10-year risk of a cardiovascular event of 10% or greater Screen universal lipids at every well-visit for those with increased risk of heart disease and at least every 6 years for healthy adults.			

Adult Preventive Care		Yes	No	Comments:
12.	Hepatitis B Virus Screening: Perform risk assessment at each well visit (e.g., individuals born in Sub-Saharan Africa: Egypt, Algeria, Morocco, Libya, etc.; Central and Southeast Asia: Afghanistan, Vietnam, Cambodia, Thailand , Philippines, Malaysia, Indonesia, Singapore, etc.; HIV+, IV drug users, MSM, household contact with HBV infected individuals). Those at risk should include testing to three HBV screening seromarkers (HBsAg, antibody to HBsAg anti HBs, and antibody to hepatitis B core antigen anti-HBc) so that persons can be classified into the appropriate hepatitis B category and properly receive vaccination, counseling, and linkage to care and treatment https://www.cdc.gov/hepatitis/hbv/hbvfaq.htm			
13.	Hepatitis C Virus Screening: All adults 18 to 79 years old shall be assessed for risk of Hepatitis C Virus (HCV) exposure at each well visits. Test at least once between ages 18 to 79. Persons with increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually. Hepatitis C testing is also recommended for all pregnant women during each pregnancy, those receiving long term hemodialysis, those with HIV, prior recipients of transfusions or organ transplant before July 1992 or donor who later tested positive for HCV infection, persistently abnormal ALT levels, and those who received clotting factor concentrates produced before 1987. Testing should be initiated with anti-HCV. For those with reactive test results, the anti-HCV test should be followed with an HCV RNA. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis- c-screening https://www.cdc.gov/hepatitis/hcv/guidelinesc.htm			
14.	High Blood Pressure Screening: Screen at each well visit. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hypertens ion-in-adults-screening			
15.	HIV Screening: USPSTF recommends risk assessment shall be completed at each well visit for patients 65 years old and younger. Those at high risk (i.e., having intercourse without a condom or with more than one sexual partner whose HIV status is unknown, IV drug users, MSM) regardless of age shall be tested for HIV and offered pre-exposure prophylaxis (PrEP). Lab results are documented.			
16.	Intimate Partner Violence (IPV) Screening: Perform at each well visit for female patients of reproductive age, regardless of sexual activity, using screening tools such as Humiliation, Afraid, Rape, Kick (HARK); Hurt, Insult, Threaten, Scream (HITS); Extended–Hurt, Insult, Threaten, Scream (E-HITS); Partner Violence Screen (PVS); and Woman Abuse Screening Tool (WAST). Reproductive age is defined across studies as ranging from 12 to 49 years, with most research focusing on women age 18 years or older. IPV describes physical, sexual, or psychological harm by a current or former partner or spouse. Provide or refer those who screen positive to ongoing support services. The Staying Healthy Assessment (SHA) forms only assess for presence of physical violence and lacks the questions to assess for emotional components of abuse to adequately screen for IPV. The SHA is an incomplete tool to screen for IPV.			

Adult Preventive Care		Yes	No	Comments:
17.	Lung Cancer Screening: Assess all individuals during well adult visits for past current and current tobacco use. Adults ages 50 to 80 years who have a 20-pack-year smoking history (e.g.,1 pack per day for20 years or 2 packs per day for 10 years) and currently smoke or have quit within the past 15 years,			
	shall be screened annually with low-dose computed tomography. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/lung-cancer-screening			
18.	Obesity Screening and Counseling: Document weight and BMI at each well The USPSTF recommends that clinicians screen all adult patients for obesity offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults (BMI 30 or greater). https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummFinal/obesity-in-adults-interventions			
19.	Osteoporosis Screening: Assess all postmenopausal women during well adult visits for risk of osteoporosis. USPSTF recommends screening for with bone measurement testing to prevent osteoporotic fractures in women 65 years and older and in women younger than 65 with one of the following risk factors: parental history of hip fracture, smoking, excessive alcohol consumption, or low body weight. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/osteoporosis-screening			
20.	Sexually Transmitted Infection (STI) Screening and Counseling: Assess all individuals at each well visit for risk of STI and test those at risk and offer testing and perform intensive behavioral counseling for adults who are at increased risk for STIs includes counseling on use of appropriate protection and lifestyle: a. Chlamyd ia and gonorrhea: Test all sexually active women under 25 years old and older women who have new or multiple sex partners. Test MSM regardless of condom use and persons with HIV at least annually. b. Syphilis: Test MSM regardless of condom use and persons with HIV at least annually. c. Trichomonas: Test all sexually active women seeking care for vaginal discharge, women who are IV drug users, women who exchange sex payment, women with HIV or have history of STI. d. Herpes: Test all men and women requesting STI evaluation who have multiple sex partners, those with HIV and MSM with undiagnosed genital tract infection https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/sexually-transmitted-infections-behavioral-counseling			
21.	Tobacco Use Screening Counseling and Interventions: Assess all patients during well adult visits for tobacco use and document prevention and/or counseling services to potential/active tobacco users. If the PCP identifies tobacco use (i.e., patient answered *Yes* on IHEBA (see Adult SHA Q17 or Senior SHA Q21), documentation that the provider offered tobacco cessation services, behavioral counseling, and /or pharmacotherapy to include any or a combination of the following must be in the patient's medical record: • FDA-ap proved tobacco cessation medications (for non-pregnant adults of any ag e) • Individual, group, and telephone counseling for members of any ag e who use tobacco's products • Services for pregnant tobacco users			

Adult Preventive Care		Yes	No	Comments:
22.	Tuberculosis Screening: Adults are assessed for TB risk factors or symptomatic assessments upon enrollment and at periodic physical evaluations. The Mantoux skin test, or other approved TB infection screening test, is administered to all asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they had not had a test in the previous year. Adults already known to have HIV or who are significantly immunosuppressed require annual TB testing. The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care (e.g., further medical evaluation, chest x-ray, diagnostic laboratory studies, and/or referral to specialist). https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/latent-tuberculosis-infection-screening https://www.cdc.gov/tb/publications			
23.	Adult Immunizations: Immunization status must be assessed at periodic health evaluations with evidence of the following: • Given according to ACIP guidelines • Vaccine administration documentation • Vaccine Information Statement (VIS) documentation Vaccination status must be assessed for the following: • Td/Tdap (every 10 years) • Flu (annually) • Pneumococcal (ages 65 and older; or anyone with underlying conditions) • Zoster (starting at age 50) https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html			

MEDICAL RECORD POLICY AND PROCEDURES

Security of Medical Records

1. The medical record will be secure and inaccessible to unauthorized persons in order to prevent loss, tampering, disclosure of information, alteration or destruction of the record.

2. Information must be accessible only to authorized staff within the physician's office, contracted health plans, DHS or to persons authorized through a legal instrument (i.e., subpoena).

3. As per the Provider Agreement/Contract, provisions must be made for the contracted health plan to have appropriate access to the member's medical records for purpose of quality review.

Release of Medical Records and Distribution

1. Patient information and records shall be protected for confidentiality according to the Confidentiality of Medical Information Act which prohibits a provider of health care from disclosing any individually identifiable information regarding a patient's written consent or specific legal authority.

2. Patient information in a medical record may only be released under the following conditions:

    a. The attorney or representative of the patient may receive a copy of the medical record after presenting a signed authorization from the patient or his/her representative. The patient must present identification when requesting a copy of his/her medical record. Outside health care providers: Federal, State, County or City agencies; employers; and insurance companies may also receive a copy of the patient record, with the patient's authorization.
    b. Any release in response to a court order or to authorized persons will be reported to the patient in a timely manner.
    c. Member records may be disclosed, with or without patient authorization, to qualified personnel for the purpose of conducting scientific research, but these records must not identify, directly or indirectly, an individual patient in any report of the research or otherwise disclose participant identity in any manner to prevent divulging confidential information.
    d. In accordance with individual Provider Agreements/Contracts, health plan representatives are provided appropriate access to members' medical records for the purpose of quality review.

3. Only the Medical Record Department or assigned personnel responsible for the maintenance of medical records may provider written documents or copies of patient records.

4. Authorization forms permitting release of medical records must specify whom the information is requested by, the type of information requested and the dated signature of the patient or patient representative. The patient's name, medical record number, name and organization of the requester, date of the request and date the record was released must be documented and filed in the medical record.

5. Minors have the right to access confidential services without parental consent, therefore those medical records and/or information regarding medical treatment specific to those confidential services are not to be released to parent(s) without the minor's consent.

Storage and Maintenance

1. Medical records will be stored in one central medical record area and must be inaccessible to unauthorized persons. The medical record area need not be locked if staff is present.

2. Medical records are to be maintained in a manner that is current, detailed, organized; permits effective patient care and quality review and maintain confidentiality.

3. All medical records will be maintained for a minimum of ten (10) years following patient discharge, except minors. Records of minors must be maintained for at least (1) year after a minor has reached age 18, but in no event for less than ten (10) years.

4. Printed chart contents will securely fastened, attached or bound to prevent medical record loss.

5. The records must be filed alphabetically, numerically and/or color coded for easy retrieval.

6. Each patient must have his own medical record. No "family" charts are allowed.

7. Medical records will allow for prompt retrieval of the medical records and must be available to the provider at each encounter.

8. Medical records will be properly filed. They will not be piled on the floor, tumbling out of the racks/storage nor packed tightly in the racks so as to obstruct access.

9. Medical records are not to be accessible to patients, therefore must be collected after use a put in the assigned area.

10. Medical records with lab, x-ray or consultation reports or other information that has not yet been reviewed by the provider will be collected and stored in a predetermined area for the provider's review.

Consent for Treatment

1. Consent for treatment must be given at the time of initial office visit by the member, parent or guardian by signing a consent to treat form for either an adult or child as appropriate.

2. The consent to treat form will be maintained in the patient's medical record.

3. Minors have the right to access confidential services without parental consent. Therefore minors are authorized to sign their consent to treat form for any confidential services and/or information regarding medical treatment specific to those confidential services. Records and information are not to be released to parent(s) without the minor's consent.

Medical Record Documentation

1. The medical record system permits prompt retrieval of information.

2. All pages in the medical record will be filed chronologically.

3. Each page in the medical record must have member identification that includes the member's first and last name and/or a unique patient number (date of birth, medical record number, social security number).

4. The medical record will contain personal/biographical and demographic data that includes, but is not limited to, name, date of birth, age, sex, address, and telephone number and marital status. This information will be updated annually or as appropriate.

5. The medical record will include documentation regarding the member's emergency contact information. This will include the name and phone number of a relative or friend or a home, work, pager, cellular or message phone number. If the patient is a minor, the emergency contact must be a parent or guardian. Refusal or absence of an emergency contact must be noted in the medical record.

6. The member's primary language will be noted in the medical record.

7. The linguistic services needs for non- or limited English proficient members will be prominently noted in the medical record. Request for language and/or interpretation services will be documented. The member's refusal of these services will also be documented.

8. Allergies and adverse reactions are noted in the medical record in a prominent and consistent location. Absence of allergies or adverse reactions must also be noted using NKAD, NKA or none.

9. A clearly identifiable problem list will be maintained in the medical record that identifies all chronic and/or significant problems. The problem list will be currently maintained and will include a date the problem was identified as well as a date the problem was resolved (as applicable). Absence of chronic/significant problems will be noted on this list. Problems must be consistently listed in the progress notes if a problem list is not utilized.

10. A clearly identifiable medication list will be maintained in the medical record that identifies all long term or ongoing medications. This list will be currently maintained with the name of the medications. This list will be currently maintained with the name of the medication, strength, dosage, route, and start/stop dates. Discontinued medications will be noted in the progress notes and the stop date for the medication will be noted on the medication list. Medications must be consistently listed in the progress notes if a medication list is not utilized.

11. Documentation of whether the patient has executed an Advance Directive (a written instruction such as a living will or Durable Power of Attorney for health care relating to the provision of health care when the individual is incapacitated) or notation that information about Advanced Directives was given to the patient as required by Federal Law.

12. Entries are made in accordance with acceptable legal medical documentation standards. This will include:

    a. All entries are signed, dated and are legible.
    b. Signature includes the first initial, last name and title.
    c. Initials may be used only if signatures are specifically identified on a "signature page."
    d. Date includes the month, day and year.
    e. Only standard abbreviations are used in the medical record.
    f. Entries are in reasonable consecutive order by date.
    g. Notations made by hand must be made in black ink.
    h. Handwritten documentation does not include skipped lines or empty spaces where information may be added.
    i. Entries are not back dates or inserted into spaces above previous entries.
    j. Omissions are charted as new entries.
    k. Late entries are explained in the medical record and are signed and dated.

13. Entries into the medical record must be accurate, documented in a timely manner and legible to a person other than the author.

14. Errors made in the medical record will be corrected by drawing a single line through the error, with "error" written above or near the lined through entry. The corrected information is written above or near the lined through entry. The corrected

information is written as a separate entry and includes the date of the entry, signature (or initials) and title. There will be no unexplained cross outs, erased entries or use of correction fluid/tape. Both the original entry and corrected entry are clearly preserved.

15. Each focused/acute visit will include a documented history of the present illness. Physical exam relevant to the reason for the visit will be documented, which includes both normal and abnormal findings.

16. The diagnosis/impression is identified during each visit and will be documented defining the provider's conclusions.

17. Diagnostic information and a plan of treatment for each visit will be documented in the medical record.

18. Treatments, studies, procedures and tests, including results are to be documented and consistent with the diagnosis(es). Results of all diagnostic studies are filed in the medical records.

19. Specific follow-up instructions with a definite time from for a return visit or other follow-up plan for each encounter will be documented on the progress notes. The time period for return visit will be definitively stated in a number of days, weeks, months or PRN.

20. Unresolved problems from previous visits will be addressed in subsequent visits and documented on the progress notes.

21. Consultation reports, diagnostic test results, inpatient discharge reports, emergency and urgent care reports, and all abnormal and/or "STAT" reports will reflect the provider's review. The documents are to be filed in the chart within two weeks of service.

22. Provider will make explicit notations regarding abnormal test results/diagnostic reports. Documentation will include:
    a. All patient contacts
    b. Attempts made to contact patient
    c. Follow-up treatment
    d. Instructions given to patient
    e. Return office visits
    f. Referrals
    g. Other pertinent information.

23. There will be documentation of follow up for failed or missed appointments.
    Documentation will include:
    a. Attempt to contact patient/parent/guardian
    b. Results of follow-up actions.

Medical Record Signature Sheet			
Print Name	**Title**	**Signature**	**Initials**

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

45 CFR 164.520

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in *plain language* that describes:

- How the covered entity may use and disclose protected health information about an individual.

- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.

- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.

- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.

- A covered entity must prominently post and make available its notice on any website it maintains that provides information about its customer services or benefits.

- *Health Plans* must also:

  < Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
  < Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
  < Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.

- *Covered Direct Treatment Providers* must also:

- < Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
- < When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
- < In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
- < Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.

- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options.

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.

- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service

delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

Frequently Asked Questions

http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php
then select "Privacy of Health Information/HIPAA"

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization : In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

PATIENT ACKNOWLEDGEMENT OF
THE NOTICE OF PRIVACY PRACTICES
AND CONSENT FOR USE AND DISCLOSURE OF
PERSONAL HEALTH INFORMATION

_____

Print Patient's Name Date

I,_____, acknowledge that I
(Signature of Patient or Parent or Legal Guardian)

Have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I,_____, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

My personal health information by your office for Treatment, Billing / Payment and Health care Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

GENERAL CONSENT

I hereby request and consent to diagnostic procedures, including x-rays, blood tests, medical treatments, including immunizations, and dental treatments deemed advisable by the professional staff of: _ _____

I acknowledge that I have this consent form and understand its contents. I have had an opportunity to discuss it and any questions I had have been answered to my complete satisfaction.

Witness

Patient Signature

Date

Parent/Legal Guardian's Signature

CONSENTIMIENTO GENERAL ..

Por este media hago peticion y el consentimiento para los procedimientos de diagnostico, como radiograffas, analisis de sangre, tratamientos medicos, incluyendo vacunas y tratamientos dentales que se consideran aconsejables por el personal profesional de: _____

Reconozco que tengo este formulario de consentimiento y entiendo su contenido. He tenido la oportunidad de discutir de ello y todas las preguntas que ten,a han sido contestadas a mi entera satisfaccion.

Testigo

Firma del paciente

Fecha

Firma del Padre / Guardian Legal

Informed Consent

Patient Name: _____

Date of Birth: _____

I acknowledge that I have been advised by _____ (provider name) that I undergo the following procedure(s) in the office:

_____

_____

I understand that this procedure will be done by the above provider and that the risks of this procedure (including the risk of anesthesia), as well as the alternatives and the risks associated with each alternative, have been explained to me. I acknowledge these risks, and give my consent to the procedure described above.

Patient Signature: _____ Date: _____

Provider Signature: _____

Witness Signature: _____

Advance Directives: The Basics

Advance directives are legal documents that allow you to put in writing what kind of health care you would want if you were too ill to speak for yourself. Advance directives most often include the following documentation:

- A health care proxy (durable power of attorney)
- A living will
- After-death wishes

Talking with your family, friends, and health care providers about your wishes is important, but these legal documents ensure your wishes are followed. It's better to think about these important decisions before you are ill or a crisis strikes.

A *health care proxy* (sometimes called a durable power of attorney for health care) is used to name the person you wish to make health care decisions for you if you aren't able to make them yourself. Having a health care proxy is important because if you suddenly aren't able to make your own health care decisions, someone you trust will be able to make these decisions for you.

A *living will* is another way to make sure your voice is heard. It states which medical treatment you would accept or refuse if your life is threatened. Dialysis for kidney failure, a breathing machine if you can't breathe on your own, CPR (cardiopulmonary resuscitation) if your heart and breathing stop, or tube feeding if you can no longer eat are all examples of medical treatment you can choose to accept or refuse.

In some states, advance directives can also include after-death wishes. This may include choices such as organ and tissue donation.

If you already have advance directives, take time now to review them to be sure you are still satisfied with your decisions and your health care proxy is still willing and able to carry out your plans. Find out how to cancel or update them in your state if they no longer reflect your wishes. **Make sure to give your new advance directives to your doctors, proxy, and family members.**

Each state has its own laws for creating advance directives. For more information, contact your health care provider, an attorney, your local Area Agency on Aging, or your state health department.

Tips

1. Keep the original copies of your advance directives where they are easily found.
2. Give the person you've named as your health care proxy, and other concerned family members or friends, a copy of your advance directives.
3. Give your doctor a copy of your advance directives for your medical record. Provide a copy to any hospital or nursing home you stay in.
4. Carry a card in your wallet that states you have advance directives.

Source: Department of Health and Human Services. (2009, September). In *Medicare and you 2010*. Retrieved December 2, 2009, from http://www.medicare.gov/

Advance Health Care Directive Form Instructions

You have the right to give instructions about your own health care.

You also have the right to name someone else to make health care decisions for you.

The Advance Health Care Directive form lets you do one or both of these things. It also lets you write down your wishes about donation of organs and the selection of your primary physician. If you use the form, you may complete or change any part of it or all of it. You are free to use a different form.

INSTRUCTIONS

Part 1: Power of Attorney

Part 1 lets you:

- **name** another person as **agent** to make health care decisions for you if you are unable to make your own decisions. You can also have your agent make decisions for you right away, even if you are still able to make your own decisions.
- **also name** an **alternate agent** to act for you if your first choice is not willing, able or reasonably available to make decisions for you.

Your **agent** may not be:

- an operator or employee of a community care facility or a residential care facility where you are receiving care.
- your supervising health care provider (the doctor managing your care)
- an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Your **agent** may make all health care decisions for you, unless you limit the authority of your agent. You do not need to limit the authority of your agent.

If you want to limit the authority of your agent the form includes a place where you can limit the authority of your agent.

If you choose not to limit the authority of your agent, your agent will have the right to:

- Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- Choose or discharge health care providers (i.e. choose a doctor for you) and institutions.
- Agree or disagree to diagnostic tests, surgical procedures, and medication plans.
- Agree or disagree with providing, withholding, or withdrawal of artificial feeding and fluids and all other forms of health care, including cardiopulmonary resuscitation (CPR).
- After your death make anatomical gifts (donate organs/tissues), authorize an autopsy, and make decisions about what will be done with your body.

Part 2: Instructions for Health Care

You can give specific instructions about any aspect of your health care, whether or not you appoint an agent.

There are choices provided on the form to help you write down your wishes regarding providing, withholding or withdrawal of treatment to keep you alive.

You can also add to the choices you have made or write out any additional wishes.

You do not need to fill out part 2 of this form if you want to allow your agent to make any decisions about your health care that he/she believes best for you without adding your specific instructions.

Part 3: Donation of Organs

You can write down your wishes about donating your bodily organs and tissues following your death.

Part 4: Primary Physician

You can select a physician to have primary or main responsibility for your health care.

Part 5: Signature and Witnesses

After completing the form, **sign and date it** in the section provided.

The form must be signed **by two qualified witnesses** (see the statements of the witnesses included in the form) **or** acknowledged before a notary public. **A notary is not required if the form is signed by two witnesses. The wittnesses must sign the form on the same date it is signed by the person making the Advance Directive.**

See part 6 of the form if you are a patient in a skilled nursing facility.

Part 6: Special Witness Requirement

A Patient Advocate or Ombudsman must witness the form ***if you are a patient in a skilled nursing facility*** (a health care facility that provides skilled nursing care and supportive care to patients). See Part 6 of the form.

You have the right to change or revoke your Advance Health Care Directive at any time

If you have questions about completing the Advance Directive in the hospital, please ask to speak to a Chaplain or Social Worker.

We ask that you
complete this form in English
so your caregivers can understand your directions.

ADVANCE DIRECTIVE STATUS

I have been informed of my right to formulate an Advance Directive and I have been provided with information regarding the execution of an Advance Directive.

Please check one of the following:

[ ] I have previously completed an Advance Directive and have provided a copy for inclusion in my record.

[ ] A copy of my Advance Directive is on file with _____.
(Physician or health care facility)

[ ] I have not executed an Advance Directive and I am not interested in any further information.

[ ] I am interested in the formulation of an Advance Directive and will discuss my options with my primary care provider.

_____ _____
Patient's Signature Date

Comments:

_____

_____

_____

_____

[ ] The patient was given a brochure/information on Advance Directives.

_____ _____
Practitioner and/or Staff's Signature Date

Patient Name	DOB:

Advance Health Care Directive

Name_____

Date_____

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form also lets you write down your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or change all or any part of it. You are free to use a different form.

You have the right to change or revoke this advance health care directive at any time.

Part 1 — Power of Attorney for Health Care

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent:_____

Relationship_____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

ALTERNATE AGENT (Optional): If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as alternate agent:_____

Relationship_____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

SECOND ALTERNATE AGENT (optional): If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: _____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

(1.2) AGENT'S AUTHORITY: My agent is authorized to 1) make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, 2) to choose a particular physician or health care facility, and 3) to receive or consent to the release of medical information and records, except as I state here:

_____

_____

(Add additional sheets if needed.)

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I initial the following line.

If I initial this line, my agent's authority to make health care decisions for me takes effect immediately. ____

(1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POST DEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named. _____ (initial here)

Part 2 — Instructions for Health Care

If you fill out this part of the form, you may strike out any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct my health care providers and others involved in my care to provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ a) Choice Not To Prolong
I do not want my life to be prolonged if the likely risks and burdens of treatment would outweigh the expected benefits, or if I become unconscious and, to a realistic degree of medical certainty, I will not regain consciousness, or if I have an incurable and irreversible condition that will result in my death in a relatively short time.

Or

☐ b) Choice To Prolong
I want my life to be prolonged as long as possible within the limits of generally accepted medical treatment standards.

(2.2) OTHER WISHES: If you have different or more specific instructions other than those marked above, such as: what you consider a reasonable quality of life, treatments you would consider burdensome or unacceptable, write them here.

_____

_____

_____

_____

_____

Add additional sheets if needed.)

Part 3 — Donation of Organs at Death (Optional)

(3.1) Upon my death (mark applicable box):

☐ I give any needed organs, tissues, or parts

☐ I give the following organs, tissues or parts only:_____

☐ I do not wish to donate organs, tissues or parts.

My gift is for the following purposes (strike out any of the following you do not want):

Transplant Therapy Research Education

Part 4 — Primary Physician (Optional)

(4.1) I designate the following physician as my primary physician:

Name of Physician:_____

Address: _____

_____

Telephone: _____

Part 5 — Signature

(5.1) EFFECT OF A COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign name: _____ Date: _____

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly nor an employee of an operator of a residential care facility for the elderly.

FIRST WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

SECOND WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate on his or her death under a will now existing or by operation of law.

Signature of Witness: _____

Signature of Witness: _____

Part 6 — Special Witness Requirement if in a Skilled Nursing Facility

(6.1) The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OF OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by section 4675 of the Probate Code:

Print Name:_____ Signature: _____

Address: _____ Date: _____

Certificate of Acknowledgement of Notary Public (Not required if signed by two witnesses)

State of California, County of _____ On this _____ day of _____ , _____ , before me, the undersigned, a Notary Public in and for said State, personally appeared _____ , personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument, and acknowledged

to me that he/she executed it.

WITNESS my hand an official seal. Seal

Signature_____

SECTION	Approval date:	
Medical Records Documentation	**Approved by:**	
POLICY AND PROCEDURE	**Effective date:**	
Advance Health Care Directive	**Revision date:**	

POLICY:

Adults 18 years of age or older and emancipated minors shall be offered information or has executed an Advance Healthcare Directive (California Probate Code, Sections 4701).

PROCEDURE:

III. Advance healthcare directive (advance directive) shall be discussed with each member 18 years of age or older. State and Federal requirements shall be followed accordingly. An advance directive outlines a patient's preferred types of health care services and treatments and designates who is to speak on the patient's behalf if he or she becomes incapable of making personal health care decisions. According to the Federal Patient Self Determination Act (PSDA), patients with decision-making capabilities have the right to accept or refuse medical treatment or life sustaining procedures. Health plan policies states that adult members, age 18 years or older, has the right to prepare an advance directive.

Discussing and pre-paring advance directives with patients can:

a) Ensure the care and services desired by the patients are provided according to his or her wishes, including the refusal of treatment.
b) Designate the person who is delegated to make decisions on the patient's behalf if he or she becomes incapable of making such decisions.
c) Ensure family and friends abide by the wishes of the patient regarding the type of care and treatment determined in advance.

IV. DOCUMENTATION

Providers shall consider discussing advance directive during routine office visits with members, instead of waiting until a member is acutely ill. The Advance Medical Directive reference is available, in English and Spanish, and is attached to this policy.

If an advance directive is prepared by member, encourage the member to share a copy with his or her family to notify them about who is designated to make decisions on the member's behalf in the event he or she can no longer make personnel health care decisions. This may initiate early health care planning discussions to enable a smoother transition before there is a medical crisis. It should be documented in the patient's medical record whether an advance directive had been discussed or executed, if possible. A copy shall be in the medical record and updated every 5 years.

V. ADDITIONAL INFORMATION

Physician orders for life-sustaining treatment (POLST) programs provide an organized process for completing advance directives. More information on advance directives and POLST are available on the following web sites:

- www.chcf.org/topic/serious-illness-end-of-life-care/
- www.cancer.org/index

Comprehensive Health Assessment - Annual

Name: **DOB:**

50+ Years: Female	Actual Age:	Date:	
Medical Record #			
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		
Advance Directive Info Given/Discussed	☐ Yes ☐ Refused		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List ☐ taking 0.4 to 0.8 mg of folic acid daily (for reproductive females)			
Limitations (physical or mental):			
Interval History			
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 2 ½ hrs per week w/ 2 days strength training)		
Weight ☐ Loss ☐ Gain	_____ lbs ☐ Intentional ☐ Unintentional		
LMP:	G P A	☐ Menorrhagia ☐ Menopause	
Hysterectomy	☐ Partial ☐ Total		
Sexually active	☐ Yes ☐ No ☐ Multiple Partners		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
Last PAP	Date:	☐ WNL	
Last Mammogram	Date:	☐ WNL	
Last Colonoscopy	Date:	☐ WNL	
Current Alcohol / Substance Use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:	
Family History	☐ None	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Hip fracture	
☐ High cholesterol	☐ Cancer	☐ Other:	

Immunization History / Date	☐ None ☐ See CAIR	☐ Tdap:
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Varicella:
☐ COVID Booster(s):	☐ MMR:	☐ Zoster:
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:

USPSTF Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Breast Cancer	☐ H&P, ☐ Other:	☐	☐
Cervical Cancer	☐ H&P, ☐ Other:	☐	☐
Colorectal Cancer	☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Hepatitis C	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Lung Cancer	☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Osteoporosis	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Screener, ☐ H&P, ☐ Other:	☐	☐

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐

Comprehensive Health Assessment - Annual

Name: **DOB:**

Genitalia	Grossly normal	☐
Female	No lesions, normal external appearance	☐
Vaginal exam	Done or completed elsewhere OB/GYN name:	☐
Femoral pulses	Present & equal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ OB/GYN	☐ Other:	

Orders

☐ COVID 19 vaccine / booster	☐ Hep B Panel (if high risk)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep C Antibody test (if high risk)	☐ Hct / Hgb ☐ Lipid panel
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ MMR (if not up to date)	☐ HIV ☐ Herpes	☐ CXR ☐ Urinalysis
☐ Pneumococcal	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test
☐ Tdap	☐ Rx for folic acid 0.4-0.8mg daily	☐ Fasting plasma glucose ☐ Oral glucose tolerance test
☐ Varicella (if not up to date)	☐ gFOBT or Fit ☐ Colonoscopy	☐ HbA1C ☐ Low to moderate dose statin
☐ Zoster	☐ PAP ☐ Mammogram ☐ Bone Density Test	☐ Low Dose CT (20-pack year smoking history & currently smoke or have quit within past 15 years)
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Mental health (emotional support)	☐ Violent behavior	☐ Goals in life
☐ Diabetes management	☐ Mindful of daily movements	☐ Work or retirement activities
☐ Sex education (partner selection)	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Family support, social interaction & communication
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt	☐ Self-breast exam
☐ Smoking/vaping use/exposure	☐ Safety helmet	☐ Aging process
☐ Routine dental care	☐ ASA use	☐ Perimenopause education

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 5/25/22

Comprehensive Health Assessment - Annual

50+ Years: Male	Actual Age:	Date:	
Medical Record #			
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		
Advance Directive Info Given/Discussed	☐ Yes ☐ Refused		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Limitations (physical or mental):			

Interval History		
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:	
Appetite	☐ Good ☐ Fair ☐ Poor	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 2 ½ hrs per week w/ 2 days strength training)	
Weight ☐ Loss ☐ Gain	_____ lbs ☐ Intentional ☐ Unintentional	
Sexually active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM	
Contraceptive Used	☐ None ☐ Condoms ☐ Other:	
Last Colonoscopy	Date: ☐ WNL	
Current Alcohol / Substance Use	☐ None	☐ Alcohol
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Other:
Immunization History / Date	☐ None ☐ See CAIR	☐ Tdap:
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Varicella:
☐ COVID Booster(s):	☐ MMR:	☐ Zoster:
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:

Name: **DOB:**

USPSTF Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Abdominal Aortic Aneurism	☐ H&P, ☐ Other:	☐	☐
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Colorectal Cancer	☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Hepatitis C	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Lung Cancer	☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ /uncircumcised, testes in scrotum Prostate Exam / Rectal	☐
Femoral pulses	Present & equal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐

Comprehensive Health Assessment - Annual

Name: **DOB:**

Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ Other:		

Orders

☐ COVID 19 vaccine / booster	☐ Hep B Panel (if high risk)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep C Antibody test (if high risk)	☐ Hct / Hgb ☐ Lipid panel
☐ Influenza	☐ Chlamydia ☐ Gonorrhea	☐ Low to moderate dose statin
☐ MMR (if not up to date)	☐ HIV ☐ Herpes	☐ PPD skin test ☐ QFT
☐ Pneumococcal	☐ Syphilis ☐ Trichomonas	☐ CXR ☐ Urinalysis
☐ Tdap	☐ gFOBT or Fit ☐ Colonoscopy	☐ ECG ☐ COVID 19 test
☐ Varicella (if not up to date)	☐ Low Dose CT (20-pack year smoking history & currently smoke or have quit within past 15 years)	☐ Fasting plasma glucose ☐ Oral glucose tolerance test
☐ Zoster	☐ AAA Ultrasound (65 to 75 who have ever smoked >100 cigarettes in lifetime)	☐ HbA1C ☐ PSA
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Diabetes management	☐ Violent behavior	☐ Goals in life
☐ Sex education (partner selection)	☐ Mindful of daily movements	☐ Work or retirement activities
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Family support, social interaction & communication
☐ Smoking/vaping use/exposure	☐ Seat belt	☐ Testicular self-exam
☐ Routine dental care	☐ Safety helmet	☐ Aging process

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 5/25/22

Adult Preventive Health Care Schedule: Recommendations from the USPSTF *(as of June 18, 2021)*

To be used in conjunction with USPSTF recommendation statements (for additional details see tables and references at https://www.aafp.org/afp/PHCS)

Only grade A/B recommendations are shown

Age	18	21	24	25	35	40	45	50	55	59	65	70	74	75	80
USPSTF screening recommendations															
Alcohol misuse[1]	(B)														
Depression[2]	(B)														
Hypertension[3]	(A)														
Obesity/weight loss[4]	(B) if BMI 30 kg per m^2 or greater														
Tobacco use and cessation[5]	(A)														
Hepatitis C virus infection[6]	(B)														
HIV infection[7]	(A)											(A) if at increased risk			
Hepatitis B virus infection[8]	(B) if at increased risk														
Syphilis[9]	(A) if at increased risk														
Tuberculosis[10]	(B) if at increased risk														
BRCA gene risk assessment[11]	(B) if appropriate personal or family history of ***BRCA***-related cancer or ancestry														
Chlamydia and gonorrhea[12]	(B) if sexually active	(B) if at increased risk													
Intimate partner violence[13]	(B) women of childbearing age														
Cervical cancer[14]		(A) See p. 3 for test options and screening intervals													
Abnormal glucose/type 2 diabetes mellitus[15]						(B) if overweight or obese									
Colorectal cancer[16]							(B)	(A)							
Breast cancer[17]								(B) biennial screening							
Lung cancer[18]								(B) if 20-pack-year history and current or former smoker (quit in past 15 years)							
Osteoporosis[19]							(B) if postmenopausal and elevated risk				(B)				
Abdominal aortic aneurysm[20]											(B) if an "ever smoker"				
Unhealthy drug use[21]	(B)														
USPSTF preventive therapies recommendations															
HIV preexposure prophylaxis[22]	(A) if at high risk of HIV infection														
Primary prevention of breast cancer[23]	(B) offer if at increased risk for breast cancer and low risk for side effects														
Folic acid supplementation[24]	(A) if capable of conceiving														
Statins for primary prevention of CVD[25]						(B) see criteria on p. 4									
Aspirin for primary prevention of CVD and colorectal cancer[26]								(B) if ≥ 10% 10-year CVD risk							
Fall prevention in community-dwelling older adults[27]											(B) exercise interventions if at increased fall risk				
USPSTF counseling recommendations															
Sexually transmitted infection prevention[28]	(B) if at increased risk														
Diet/activity for CVD prevention[29]	(B) adults with CVD risk factors														
Skin cancer prevention[30]	(B) if fair skinned														
Healthy weight gain in pregnancy[31]	(B) all pregnant women														

Legend	Normal risk	With specific risk factor
Recommendation for men and women		
Recommendation for men only		
Recommendation for women only		

Recommendation grades	
A	Recommended (likely significant benefit)
B	Recommended (likely moderate benefit)
C	Do not use routinely (benefit is likely small)
D	Recommended against (likely harm or no benefit)
I	Insufficient evidence to recommend for or against

BMI = body mass index; CVD = cardiovascular disease; USPSTF = U.S. Preventive Services Task Force.

Visual adaptation from recommendation statements by Swenson PF, Lindberg C, Carrilo C, and Clutter J.

CABC-CDMMP-000029-22 June 2022

HIV RISK FACTORS

- IV drug use
- Men who have sex with men
- Other STI
- Requesting STI testing
- Sex exchanged for drugs or money
- Sex with individuals who are IV drug users, bisexual, or HIV positive
- Unprotected sex, including anal intercourse

Patients in whom to consider PrEP:

Sexually active men who have sex with men who have any of the following:

- Sexual relationship with serodiscordant partner
- Inconsistent use of condoms during anal sex
- Syphilis, gonorrhea, or chlamydia infection in past six months

Sexually active heterosexual patients with any of the following:

- Sexual relationship with serodiscordant partner
- Inconsistent use of condoms with high-risk partner
- Syphilis or gonorrhea infection in past six months

Injection drug users with any of the following:

- Shared drug-injection equipment
- Risks of infection through sex (see above)

IV = intravenous; PrEP = preexposure prophylaxis; STI = sexually transmitted infection.

HEPATITIS B INFECTION RISK FACTORS

- HIV infection
- Infected sex partner
- Intravenous drug use
- Living with an infected individual
- Men who have sex with men
- Origin from regions* with prevalence ≥ 2%
- U.S.-born children of immigrants from regions* with prevalence ≥ 8%, if unvaccinated

*—Risk of regions can be found at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5708a1.htm.

SYPHILIS RISK FACTORS

- High-risk sexual behaviors
- Incarceration
- Local prevalence
- Men who have sex with men
- Sex exchanged for drugs or money

TUBERCULOSIS RISK FACTORS

- Health professionals*
- Homelessness, including former
- Immunosuppression*
- Prisoners, including former
- Residents of high-risk regions, including former

*—Evidence for screening not reviewed by the USPSTF because this is standard practice in public health and standard of care for patients with immunosuppression, respectively.

CHLAMYDIA AND GONORRHEA RISK FACTORS

- New or multiple sex partners
- Other STI, including history of STI
- Partner with STI
- Partners who have multiple sex partners
- Sex exchanged for drugs or money
- Sexually active adolescents
- Unprotected sex or inconsistent condom use

STI = sexually transmitted infection.

CARDIOVASCULAR DISEASE RISK FACTORS

- Atherosclerotic cardiovascular disease risk ≥ 7.5%
- Dyslipidemia
- Hypertension or elevated blood pressure
- Metabolic syndrome

BREAST CANCER RISK FACTORS

Consider use of a risk-assessment model for patients with a history of biopsy or positive family history

SEXUALLY TRANSMITTED INFECTION RISK FACTORS

Similar to those risk factors listed previously for sexually transmitted infections; consider local and population-based prevalence in individual risk assessment

Adult Preventive Health Care Schedule: Recommendations from the USPSTF

Grade A/B Recommendations (with Associated Grade C/D/I Recommendations):

Alcohol misuse screening[1]

(B) Screen adults and provide brief behavioral interventions for risky alcohol use

Depression screening[2]

(B) Screen adults with systems for evaluation and management

Hypertension screening[3]

(A) Screen adults; exclude white coat hypertension before starting therapy

Obesity/weight loss screening[4]

(B) Refer adults with obesity to intensive behavioral interventions for weight loss

Tobacco use and cessation screening[5]

(A) Screen all nonpregnant adults and provide behavior therapy and U.S. Food and Drug Administration–approved intervention therapy for cessation

(A) Screen all pregnant women and provide behavior therapy.

(I) IETRFOA electronic nicotine delivery systems for tobacco cessation

(I) Pharmacotherapy for tobacco cesation in pregnant persons

Hepatitis C virus infection screening[6]

(B) Screen adults 18 to 79 years of age

HIV infection screening[7]

(A) Screen individuals 15 to 65 years of age

(A) Screen older and younger persons who are at increased risk

Hepatitis B virus infection screening[8]

(B) Screen adolescents and adults at high risk

Syphilis screening[9]

(A) Screen individuals at increased risk

Tuberculosis screening[10]

(B) Screen individuals at increased risk

***BRCA*-related cancer risk assessment/screening**[11]

(B) Use a familial risk assessment tool (evaluated assessment tools listed in full text) in women with either:

- Personal or family history of breast, ovarian, tubal, or peritoneal cancers
- Ashkenazi Jewish ancestry (i.e., ancestry with increased risk of *BRCA* mutation)

For positive risk tools, offer genetic counseling and genetic testing, if indicated.

(D) Recommend against screening for patients without appropriate family history, personal history, or ancestry

Chlamydia and gonorrhea screening[12]

(B) Screen sexually active women 24 years and younger, and women at increased risk who are 25 years and older

(I) IETRFOA screening sexually active men

Intimate partner violence screening[13]

(B) Screen women of childbearing age and refer to appropriate services

(I) IETRFOA screening all vulnerable and older adults for abuse or neglect

Cervical cancer screening[14]

(A) Screen women

- 21 to 29 years of age every three years with cytology alone
- Frequency of screening may increase to every five years for women 30 to 65 years of age with cytology and high-risk human papillomavirus cotesting or high-risk human papillomavirus testing alone

(D) Recommend against screening in women

- 20 years and younger
- Older than 65 years if adequately screened previously and no increased risk of cervical cancer
- With hysterectomy (including cervix) without history of cervical intraepithelial neoplasia grade 2 or 3 or cervical cancer
- Younger than 30 years with human papillomavirus testing alone or in combination with cytology

Abnormal glucose and type 2 diabetes mellitus screening[15]

(B) Screen adults 40 to 70 years of age who are overweight or obese and refer patients with abnormal glucose levels for intensive counseling for healthy diet and exercise

Colorectal cancer screening[16]

(A) Screen patients 50 to 75 years of age with fecal occult blood (or immunochemical) test, sigmoidoscopy, colonoscopy, computed tomography colonography, or multitargeted stool DNA test

(B) Screen patients 45 to 49 years of age with fecal occult blood (or immunochemical) test, sigmoidoscopy, colonoscopy, computed tomography colongraphy, or multitargeted stool DNA test

(C) Selectively offer screening to patients 76 to 85 years of age

Breast cancer screening[17]

(B) Biennial screening mammography in women 50 to 74 years of age

(C) Screening is an individualized decision for women 40 to 49 years of age

(I) IETRFOA

- Mammography after 75 years of age
- Screening with digital breast tomosynthesis
- Adjunctive screening in women with dense breast tissue and negative screening mammogram

Lung cancer screening[18]

(B) Screen annually with low-dose computed tomography for individuals 50 to 80 years of age with a 20-pack-year history who currently smoke or quit within the past 15 years; discontinue screening once a person has not smoked for 15 years or develops a health problem that limits life expectancy

Osteoporosis screening[19]

(B) Screen women 65 years and older

(B) Screen postmenopausal women if increased fracture risk shown with an osteoporosis risk tool (e.g., 8.4% in 10 years by U.S. FRAX tool)

(I) IETRFOA screening men

Abdominal aortic aneurysm screening[20]

(B) Screen men 65 to 75 years of age who ever smoked (100 or greater lifetime cigarettes) with one-time abdominal aortic aneurysm ultrasonography

(C) Recommend selective screening of men 65 to 75 years who have never smoked

continues

CHD = coronary heart disease; CVD = cardiovascular disease; FRAX = Fracture Risk Assessment; IETRFOA = insufficient evidence to recommend for or against; PrEP = preexposure prophylaxis; USPSTF = U.S. Preventive Services Task Force.

Adult Preventive Health Care Schedule: Recommendations from the USPSTF *(continued)*

Grade A/B Recommendations (with Associated Grade C/D/I Recommendations): (continued)

(I) IETRFOA women 65 to 75 years of age who ever smoked

(D) Recommend against routine screening in women 65 to 75 years of age who have never smoked

Unhealthy Drug Use Screening[21]

(B) Screen all adults older than 18 years for unhealthy drug use (by asking questions, not biological specimens)

HIV prevention with PrEP[22]

(A) Offer PrEP to persons at high risk of infection. See original text for considerations in patient selection

Primary prevention of breast cancer[23]

(B) Consider medications (such as tamoxifen, raloxifene, or aromatase inhibitors) that reduce risk of breast cancer in women at increased risk though with low risk of adverse effects

(D) Recommend against routine use if no increased risk

Folic acid supplementation[24]

(A) 0.4 to 0.8 mg daily for women capable of conceiving

Statins for primary prevention of CVD[25]

(B) Recommend low- to moderate-dose statin therapy in patients meeting all three criteria:

(1) 40 to 75 years of age

(2) Dyslipidemia, diabetes, hypertension, or smoker

(3) 10-year CVD risk of 10% or greater

(C) Consider low- to moderate-dose statin therapy in appropriate candidates meeting the first two criteria but with a 10-year CVD risk of 7.5% to 10%

(I) IETRFOA initiating statin therapy after 75 years of age for primary prevention

Aspirin for primary prevention of CVD and colorectal cancer[26]

(B) Recommend low-dose aspirin for patients 50 to 59 years of age with a 10-year CVD risk of 10% or greater, appropriate bleeding risk, and life expectancy of at least 10 years

(C) Recommend individualized decision-making for patients 60 to 69 years of age who meet the same criteria

(I) IETRFOA low-dose aspirin for patients younger than 50 years or 70 years or older

Fall prevention in community-dwelling older adults[27]

(B) Recommend exercise interventions for individuals 65 years and older at increased risk of falls

(C) Recommend multifactorial interventions for appropriate individuals 65 years and older; see Clinical Considerations in original recommendation statement for patient selection

(D) Recommend against vitamin D supplementation for fall prevention

Counseling to prevent sexually transmitted infection[28]

(B) Recommend counseling to prevent sexually transmitted infection for adolescents and adults at increased risk

Counseling to promote healthy diet and physical activity[29]

(B) Recommend that patients with other CVD risk factor(s) who are overweight or obese be offered or referred for intensive behavioral counseling

Counseling for skin cancer prevention[30]

(B) Recommend counseling fair-skinned patients six months to 24 years of age about minimizing ultraviolet radiation

(C) Recommend selectively counseling fair-skinned patients older than 24 years about minimizing exposure to ultraviolet radiation

(I) IETRFOA counseling adults about skin self-examination

Counseling to promote healthy weight gain in pregnancy[31]

(B) Offer behavioral counseling interventions to promote health weight gain and to prevent excessive weight gain to all pregnant women

Grade C Recommendations:

Physical activity and healthy diet counseling to reduce cardiovascular risk in adults without obesity or known CVD risk factors[32]

Prostate cancer screening with prostate-specific antigen testing in men 55 to 69 years of age after shared decision-making[33]

Grade D Recommendations:

Bacteriuria (asymptomatic) screening in nonpregnant adults[34]

Beta carotene or vitamin E supplementation for CVD or cancer risk reduction[35]

Carotid artery stenosis screening[36]

CVD screening with resting or exercise electrocardiography in low-risk patients[37]

Chronic obstructive pulmonary disease screening with spirometry[38]

Combined estrogen-progesterone for prevention of chronic conditions or estrogen for the same in patients with hysterectomy[39]

Genital herpes screening[40]

Ovarian cancer screening[41]

Pancreatic cancer screening[42]

Prostate cancer screening with prostate-specific antigen testing in men 70 years and older[33]

Testicular cancer screening[43]

Thyroid cancer screening[44]

Vitamin D (≤ 400 IU) and calcium (≤ 1,000 mg) supplementation daily for primary prevention of fracture in postmenopausal women[45]

Grade I Statements:

Atrial fibrillation screening with electrocardiography[46]

Bladder cancer screening[47]

Celiac disease screening[48]

CVD screening in patients with nontraditional risk factors[49]

CVD screening with resting or exercise electrocardiography in intermediate- to high-risk patients[37]

Chronic kidney disease screening[50]

Cognitive impairment screening in older adults[51]

Gynecologic condition screening with pelvic examination[52]

Hearing loss screening in older adults[53]

Illicit drug use screening[54]

Impaired visual acuity screening in older adults[55]

Multivitamin, single nutrient, or paired nutrients for CVD or cancer risk reduction (beta carotene and vitamin E, as above)[35]

continues

CHD = coronary heart disease; CVD = cardiovascular disease; FRAX = Fracture Risk Assessment; IETRFOA = insufficient evidence to recommend for or against; PrEP = preexposure prophylaxis; USPSTF = U.S. Preventive Services Task Force.

Adult Preventive Health Care Schedule: Recommendations from the USPSTF *(continued)*

Obstructive sleep apnea screening[56]

Oral cancer screening[57]

Peripheral artery disease and CVD risk screening with ankle-brachial index[58]

Primary open-angle glaucoma screening[59]

Primary prevention of fractures with vitamin D and calcium supplementation (alone or combined; dose unspecified) in men or premenopausal women, and in postmenopausal women with daily dosages > 400 IU of vitamin D and > 1,000 mg of calcium[45]

Skin cancer screening[60]

Suicide risk screening[61]

Thyroid dysfunction screening[62]

Vitamin D deficiency screening in community-dwelling nonpregnant adults[63]

References

1. U.S. Preventive Services Task Force. Screening and behavioral counseling interventions to reduce unhealthy alcohol use in adolescents and adults: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2018;320(18):1899-1909.
2. Siu AL. Screening for depression in adults: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2016;315(4):380-387.
3. Krist AH, Davidson KW, Mangione CM, et al. Screening for hypertention in adults: US Preventive Services Task Force reaffirmation recommendation statement. *JAMA*. 2021;325(16):1650-1656.
4. U.S. Preventive Services Task Force. Behavioral weight loss interventions to prevent obesity-related morbidity and mortality in adults: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2018;320(11):1163-1171.
5. Krist AH, Davidson KW, Mangione CM, et al. Interventions for tobacco smoking cessation in adults, including pregnant persons: US Preventive Services Task Force recommendation statement. *JAMA*. 2021;325(3):265-279.
6. Owens DK, Davidson KW, Krist AH, et al. Screening for hepatitis C virus infections in adolescents and adults: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2020;323(10):970-975.
7. U.S. Preventive Services Task Force. Screening for HIV infection: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2019;321(23):2326-2336.
8. Krist AH, Davidson KW, Mangione CM, et al. Screening for hepatitis B virus infection in adolescents and adults: US Preventive Services Task Force recommendation statement. *JAMA*. 2020;324(23):2415-2422.
9. Bibbins-Domingo K. Screening for syphilis infection in nonpregnant adults and adolescents: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2016;315(21):2321-2327.
10. Bibbins-Domingo K. Screening for latent tuberculosis infection in adults: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2016;316(9):962-969.
11. U.S. Preventive Services Task Force. Risk assessment, genetic counseling, and genetic testing for *BRCA*-related cancer: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2019;322(7):652-665.
12. LeFevre ML. Screening for chlamydia and gonorrhea: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2014;161(12):902-910.
13. U.S. Preventive Services Task Force. Screening for intimate partner violence, elder abuse, and abuse of vulnerable adults: U.S. Preventive Services Task Force final recommendation statement. *JAMA*. 2018;320(16):1678-1687.
14. U.S. Preventive Services Task Force. Screening for cervical cancer: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2018;320(7):674-686.
15. Sui AL. Screening for abnormal blood glucose and type 2 diabetes mellitus: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2015;163(11):861-868.
16. Davidson KW, Barry MJ, Mangione CM, et al. Screening for colorectal cancer: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2021;325(19):1965-1977.
17. Siu AL. Screening for breast cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2016;164(4):279-296.
18. Krist AH, Davidon KW, Mangione CM, et al. Screening for lung cancer: US Preventive Services Task Force recommendation statement. *JAMA*. 2021;325(10):962-970.
19. U.S. Preventive Services Task Force. Screening for osteoporosis to prevent fractures: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2018;319(24):2521-2531.
20. Owens DK, Davidson KW, Krist AH, et al. Screening for abdominal aortic aneurysm: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2019;322(22):2211-2218.
21. Krist KH, Davidson KW, Mangione CM, et al. Screening for unhealthy drug use: US Preventive Services Task Force recommendation statement. *JAMA*. 2020;323(22):2301-2309.
22. U.S. Preventive Services Task Force. Preexposure prophylaxis for the prevention of HIV infection: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2019;321(22):2203-2213.
23. Owens DK, Davidson KW, Krist AH, et al. Medication use to reduce risk of breast cancer: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2019;322(9):857-867.
24. Bibbins-Domingo K. Folic acid supplementation for the prevention of neural tube defects: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2017;317(2):183-189.
25. Bibbins-Domingo K. Statin use for the primary prevention of cardiovascular disease in adults: U.S. Preventive Services recommendation statement. *JAMA*. 2016;316(19):1997-2007.
26. Bibbins-Domingo K. Aspirin use for the primary prevention of cardiovascular disease and colorectal cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2016;164(12):836-845.
27. Grossman DC. Interventions to prevent falls in community-dwelling older adults: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2018;319(16):1696-1704.
28. Krist AH, Davidson KW, Mangione CM, et al.. Behavioral counseling interventions to prevent sexually transmitted infections: US Preventive Services Task Force recommendation statement. *JAMA*. 2020;324(7):674-681.
29. Krist AH, Davidson KW, Mangione CM, et al. Behavioral counseling interventions to promote a healthy diet and physical activity for cardiovascular disease prevention in adults with cardiovascular risk factors: US Preventive Services Task Force recommendation statement. *JAMA*. 2020;324(20):2069-2075.
30. Grossman DC. Behavioral counseling to prevent skin cancer: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2018;319(11):1134-1142.
31. Davidson KW, Barry MJ, Mangione CM, et al. Behavioral counseling interventions for healthy weight and weight gain in pregnancy: US Preventive Services Task Force recommendation statement. *JAMA*. 2021;325(20):2087-2093.
32. Grossman DC. Behavioral counseling to promote a healthful diet and physical activity for cardiovascular disease prevention in adults without cardiovascular risk factors: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2017;318(2):167-174.
33. Grossman DC. Screening for prostate cancer: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2018;319(18):1901-1913.
32. Owens DK, Davidson KW, Krist AH, et al. Screening for asymptomatic bacteriuria 34 adults: US Preventive Services Task Force recommendation statement. *JAMA*. 2019;322(12):1188-1194.
35. Moyer VA. Vitamins, mineral, and multivitamin supplements for the primary prevention of cardiovascular disease and cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2014;160(8):558-564.
36. Krist AH, Davidson KW, Mangione CM, et al. Screening for asymptomatic carotid artery stenosis: US Preventive Services Task Force recommendation statement. *JAMA*. 2021;325(5):476-481.
37. U.S. Preventive Services Task Force. Screening for cardiovascular disease risk with electrocardiography: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2018;319(22):2308-2314.

Adult Preventive Health Care Schedule: Recommendations from the USPSTF *(continued)*

38. Siu AL. Screening for chronic obstructive pulmonary disease: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2016;315(13):1372-1377.
39. Grossman DC. Hormone therapy for the primary prevention of chronic conditions in postmenopausal women: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2017;318(22):2224-2233.
40. Bibbins-Domingo K. Serologic screening for genital herpes infection: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2016;316(23):2525-2530.
41. Grossman DC. Screening for ovarian cancer: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2018;319(6):588-594.
42. U.S. Preventive Services Task Force. Screening for pancreatic cancer. U.S. Preventive Services Task Force reaffirmation recommendation statement. *JAMA*. 2019;322(5):438-444.
43. Screening for testicular cancer: U.S. Preventive Services Task Force reaffirmation recommendation statement. *Ann Intern Med*. 2011;154(7):483-486.
44. Bibbins-Domingo K. Screening for thyroid cancer: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2017;317(18):1882-1887.
45. Grossman DC. Vitamin D, calcium, or combined supplementation for the primary prevention of fractures in community-dwelling adults: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2018;319(15):1592-1599.
46. Curry SJ. Screening for atrial fibrillation with electrocardiography: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2018;320(5):478-484.
47. Moyer VA. Screening for bladder cancer: U.S. Preventive Services Task Force recommendation statement [published correction appears in *Ann Intern Med*. 2011;155(6):408]. *Ann Intern Med*. 2011;155(4):246-251.
48. Bibbins-Domingo K. Screening for celiac disease: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2017;317(12):1252-1257.
49. U.S. Preventive Services Task Force. Risk assessment for cardiovascular disease with nontraditional risk factors: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2018;320(3):272-280.
50. Moyer VA. Screening for chronic kidney disease: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2012;157(8):567-570.
51. Owens DK, Davidson KW, Krist AH, et al. Screening for cognitive impairment in older adults: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2020;323(8):757-763.
52. Bibbins-Domingo K. Screening for gynecologic conditions with pelvic examination: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2017;317(9):947-953.
53. Krist AH, Davidson KW, Mangione CM, et al. Screening for hearing loss in older adults: US Preventive Services Task Force recommendation statement. *JAMA*. 2021;325(12):1196-1201.
54. Screening for illicit drug use [summary]. U.S. Preventive Services Task Force. 2008. Accessed July 1, 2015. http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/drug-use-illicit-screening
55. Siu AL. Screening for impaired visual acuity in older adults: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2016;315(9):908-914.
56. Bibbins-Domingo K. Screening for obstructive sleep apnea in adults: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2017;317(4):407-414.
57. Moyer VA. Screening for oral cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2013;160(1):55-60.
58. U.S. Preventive Services Task Force. Screening for peripheral artery disease and cardiovascular disease risk assessment with the ankle-brachial index: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2018;320(2):177-183.
59. Moyer VA. Screening for glaucoma: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2013;159(7):484-489.
60. Bibbins-Domingo K. Screening for skin cancer: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2016;316(4):429-435.
61. LeFevre ML. Screening for suicide risk in adolescents, adults, and older adults in primary care: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2014;160(10):719-726.
62. LeFevre ML. Screening for thyroid dysfunction: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2015;162(9):641-650.
63. Krist AH, Davidson KW, Mangione CM, et al.. Screening for vitamin D deficiency in adults: US Preventive Services Task Force recommendation statement. *JAMA*. 2021;325(14):1436-1442.

The CRAFFT 2.1+N Interview

To be verbally administered by the clinician

Begin: "*I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential.*"

Part A

During the PAST 12 MONTHS, on how many days did you:

1. Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Say "0" if none. ☐ # of days
2. Use any **marijuana** (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or "**synthetic marijuana**" (like "K2," "Spice")? Say "0" if none. ☐ # of days
3. Use **anything else to get high** (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? Say "0" if none. ☐ # of days
4. Use a **vaping device* containing nicotine and/or flavors,** or use any **tobacco products†?** Say "0" if none. ☐ # of days
   **Such as e-cigs, mods, pod devices like JUUL, disposable vapes like Puff Bar, vape pens, or e-hookahs. †Cigarettes, cigars, cigarillos, hookahs, chewing tobacco, snuff, snus, dissolvables, or nicotine pouches.*

If the patient answered…

"0" for all questions in Part A	"1" or more for Q. 1, 2, or 3	"1" or more for Q. 4
↓	↓	↓
Ask 1st question only in Part B below, then STOP	**Ask all 6 questions in Part B below**	**Ask all 10 questions in Part C on next page**

Part B

		Circle one	
C	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	**No**	**Yes**
R	Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	**No**	**Yes**
A	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	**No**	**Yes**
F	Do you ever **FORGET** things you did while using alcohol or drugs?	**No**	**Yes**
F	Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	**No**	**Yes**
T	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	**No**	**Yes**

Two or more YES answers in Part B suggests a serious problem that needs further assessment. See Page 3 for further instructions. →

Part C

*"The following questions ask about your use of any **vaping devices containing nicotine and/or flavors**, or use of any **tobacco products.***"*

	Circle one	
1. Have you ever tried to QUIT using, but couldn't?	**Yes**	**No**
2. Do you vape or use tobacco NOW because it is really hard to quit?	**Yes**	**No**
3. Have you ever felt like you were ADDICTED to vaping or tobacco?	**Yes**	**No**
4. Do you ever have strong CRAVINGS to vape or use tobacco?	**Yes**	**No**
5. Have you ever felt like you really NEEDED to vape or use tobacco?	**Yes**	**No**
6. Is it hard to keep from vaping or using tobacco in PLACES where you are not supposed to, like school?	**Yes**	**No**
7. When you HAVEN'T vaped or used tobacco in a while (or when you tried to stop using)…		
a. did you find it hard to CONCENTRATE because you couldn't vape or use tobacco?	**Yes**	**No**
b. did you feel more IRRITABLE because you couldn't vape or use tobacco?	**Yes**	**No**
c. did you feel a strong NEED or urge to vape or use tobacco?	**Yes**	**No**
d. did you feel NERVOUS, restless, or anxious because you couldn't vape or use tobacco?	**Yes**	**No**

One or more YES answers in Part C suggests a serious problem with nicotine that needs further assessment. See Page 3 for further instructions. ⟶

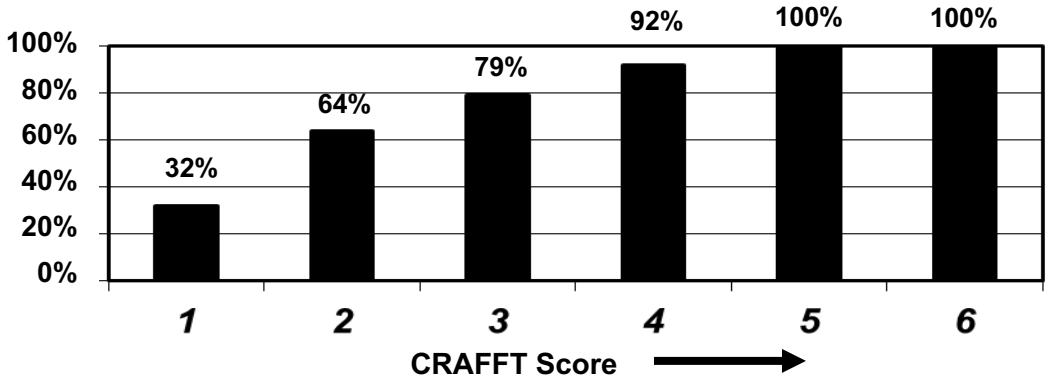
**References:*

Wheeler, K. C., Fletcher, K. E., Wellman, R. J., & DiFranza, J. R. (2004). Screening adolescents for nicotine dependence: the Hooked On Nicotine Checklist. *J Adolesc Health*, *35*(3), 225–230;

McKelvey, K., Baiocchi, M., & Halpern-Felsher, B. (2018). Adolescents' and Young Adults' Use and Perceptions of Pod-Based Electronic Cigarettes. *JAMA Network Open*, *1*(6), e183535.

CRAFFT Score Interpretation

Probability of a DSM-5 Substance Use Disorder by CRAFFT score*



*Data source: Mitchell SG, Kelly SM, Gryczynski J, Myers CP, O'Grady KE, Kirk AS, & Schwartz RP. (2014). The CRAFFT cut-points and DSM-5 criteria for alcohol and other drugs: a reevaluation and reexamination. Substance Abuse, 35(4), 376–80.

Use the 5 R's talking points for brief counseling.

1. **REVIEW** screening results
   For each "yes" response: *"Can you tell me more about that?"*

2. **RECOMMEND** not to use
   "As your doctor (nurse/health care provider), my recommendation is not to use any alcohol, nicotine, marijuana or other drug because they can: 1) Harm your developing brain; 2) Interfere with learning and memory, and 3) Put you in embarrassing or dangerous situations."

3. **RIDING/DRIVING** risk counseling
   "Motor vehicle crashes are the leading cause of death for young people. I give all my patients the Contract for Life. Please take it home and discuss it with your parents/guardians to create a plan for safe rides home."

4. **RESPONSE** elicit self-motivational statements
   Non-users: *"If someone asked you why you don't drink, vape, or use tobacco or drugs, what would you say?"* Users: *"What would be some of the benefits of not using?"*

5. **REINFORCE** self-efficacy
   "I believe you have what it takes to keep substance use from getting in the way of achieving your goals."

Give patient Contract for Life. Available at www.crafft.org/contract

crafft@childrens.harvard.edu www.crafft.org

For more information and versions in other languages, see www.crafft.org.

The Patient Health Questionnaire-2 (PHQ-2)

Instructions: Print out the short form below and ask patients to complete it while sitting in the waiting or exam room.

Use: The purpose of the PHQ-2 is not to establish a final diagnosis or to monitor depression severity, but rather to screen for depression as a "first-step" approach.

Scoring: A PHQ-2 score ranges from 0 to 6; patients with scores of 3 or more should be further evaluated with the PHQ-9, other diagnostic instrument(s), or a direct interview to determine whether they meet criteria for a depressive disorder.

Patients Name: _____ DOB: _____		Date of Visit: _____		
Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than one-half of the days	Nearly every day
1. Little interest of pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

FOR CLINIC PERSONNEL USE:

Total Score: _____

Reviewed by: _____

Provider signature: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Hepatitis Risk Assessment Tool

"Hepatitis" means inflammation of the liver and is usually caused by a virus. In the U.S., the most common types are Hepatitis A, Hepatitis B, and Hepatitis C. Millions of Americans are living with viral hepatitis but most do not know they are infected. People can live with chronic hepatitis for decades without having symptoms.

This assessment will help determine if you should be vaccinated and/or tested for viral hepatitis by asking a series of questions. Depending on your answers, you will be given a tailored recommendation that you should discuss with your doctor or your professional healthcare provider. Any information received through the use of this tool is not medical advice and should not be treated as such.

Questions	Recommendations & Explanation
1. Have you ever been diagnosed with a clotting factor disorder?	If yes, talk to your doctor about getting vaccinated for Hepatitis A.
2. Have you ever been diagnosed with a chronic liver disease?	If yes, talk to your doctor about getting vaccinated for Hepatitis A and B.
3. Were you or at least one parent born outside of the United States?	If yes, talk to a doctor about getting a blood test for Hepatitis B. Many parts of the world have high rates of hepatitis B, including the Amazon Basin, parts of Asia, Sub-Saharan Africa and the Pacific Islands.
4. Do you currently live with someone who is diagnosed with Hepatitis B?	If yes, talk to a doctor about getting a blood test for Hepatitis B.
5. Have you previously lived with someone who has been diagnosed with hepatitis B?	If yes, talk to a doctor about getting a blood test for hepatitis B.
6. Have you recently been diagnosed with a sexually transmitted disease (STD)?	If yes, talk to a doctor about getting vaccinated for Hepatitis B.
7. Have you been diagnosed with diabetes?	If yes, talk to a doctor about getting vaccinated for Hepatitis B.
8. Have you been diagnosed with HIV/AIDS?	If yes, talk to a doctor about getting vaccinated for Hepatitis B and getting a blood test for Hepatitis B and Hepatitis C.
9. If you are a man, do you have sexual encounters with other men?	If yes, talk to a doctor about getting vaccinated for Hepatitis A and B, and getting a blood test for Hepatitis B.
10. Do you currently inject drugs?	If yes, talk to a doctor about getting vaccinated for Hepatitis A and B, and getting a blood test for Hepatitis B and C.
11. Were you born from 1945-1965?	If yes, talk to a doctor about getting a blood test for Hepatitis C
12. Have you ever received a blood transfusion or organ transplant before July 1992?	If yes, talk to a doctor about getting a blood test for Hepatitis C.
13. Have you ever received a clotting factor concentrate before 1987?	If yes, talk to a doctor about getting a blood test for Hepatitis C.
14. Have you ever injected drugs, even if just once?	If yes, talk to a doctor about getting a blood test for Hepatitis C.
15. Do you plan on traveling outside of the United States within the next year?	If yes, talk to a doctor about what vaccines may be needed for travel outside the U.S.

California Adult Tuberculosis Risk Assessment

- Use this tool to identify asymptomatic **adults** for latent TB infection (LTBI) testing.
- **Do not repeat testing** unless there are **new risk factors** since the last test.
- Do not treat for LTBI until active TB disease has been excluded:
  For patients with TB symptoms or an abnormal chest x-ray consistent with active TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.

LTBI testing is recommended if any of the boxes below are checked.

☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the California Adult Tuberculosis Risk Assessment User Guide for this list).
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-U.S.-born persons ≥2 years old

☐ **Immunosuppression,** current or planned

HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease during lifetime

Treat for LTBI if LTBI test result is positive and active TB disease is ruled out.

☐ **None**; no TB testing is indicated at this time.

Provider Name: _____

Assessment Date: _____

Patient Name: _____

Date of Birth: _____

See the California Adult Tuberculosis Risk Assessment User Guide for more information about using this tool. To ensure you have the most current version, go to the TB RISK ASSESSMENT page (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TB-Risk-Assessment.aspx)

California Adult TB Risk Assessment User Guide

Avoid testing persons at low risk

Routine testing of persons without risk factors is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

Prioritize persons with risks for progression

If health system resources do not allow for testing of all non-U.S. born persons from a country with an elevated TB rate, prioritize patients with at least one of the following medical risks for progression:

- diabetes mellitus
- smoker within past 1 year
- end stage renal disease
- leukemia or lymphoma
- silicosis
- cancer of head or neck
- intestinal bypass/gastrectomy
- chronic malabsorption
- body mass index ≤20
- History of chest x-ray findings suggestive of previous or inactive TB (no prior treatment). Includes fibrosis or non-calcified nodules, but does not include solitary calcified nodule or isolated pleural thickening. In addition to LTBI testing, evaluate for active TB disease.

United States Preventive Services Task Force

The USPSTF has recommended testing persons born in or former residents of, a country with an elevated tuberculosis rate and persons who live in or have lived in high-risk congregate settings such as homeless shelters and correctional facilities. Because the increased risk of exposure to TB in congregate settings varies substantially by facility and local health jurisdiction, clinicians are encouraged to follow local recommendations when considering testing among persons from these congregate settings. The USPSTF did not review data supporting testing among close contacts to persons with infectious TB or among persons who are immunosuppressed because these persons are recommended to be screened by public health programs or by clinical standard of care.

Children

This risk assessment tool is intended for adults. A risk assessment tool created for use in California for children is available on the TBCB Risk Assessment page. (https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-Pediatric-TB-Risk-Assessment.pdf)

Local recommendations

Local recommendations and mandates should also be considered in testing decisions. Local TB control programs can customize this risk assessment according to local recommendations. **Providers should check with local TB control programs for local recommendations.** A directory of TB Control Programs is available on the CTCA website. (https://www.ctca.org/locations.html)

Mandated testing and other risk factors

Several risk factors for TB that have been used to select patients for TB screening historically or in mandated programs are not included among the components of this risk assessment. This is purposeful in order to focus testing on patients at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede any mandated testing. Examples of these populations include: healthcare workers, residents or employees of correctional institutions, substance abuse treatment facilities, homeless shelters, and others.

Age as a factor

Age (among adults) is not considered in this risk assessment. However, younger adults have more years of expected life during which progression from latent infection to active TB disease could develop. Some programs or clinicians may additionally prioritize testing of younger non-U.S.-born persons when all non-U.S.-born are not tested. An upper age limit for testing has not been established but could be appropriate depending on individual patient TB risks, comorbidities, and life expectancy.

Foreign travel

Travel to countries with an elevated TB rate may be a risk for TB exposure in certain circumstances (e.g., extended duration, likely contact with persons with infectious TB, high prevalence of TB in travel location, non-tourist travel). The duration of at least 1 consecutive month to trigger testing is intended to identify travel most likely to involve TB exposure. TB screening tests can be falsely negative within the 8 weeks after exposure, so are best obtained 8 weeks after return from travel.

When to repeat a test

Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment. In general, this would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel in certain circumstances.

When to repeat a risk assessment

The risk assessment should be administered at least once. Persons can be screened for new risk factors at subsequent preventive health visits.

IGRA preference in BCG vaccinated

Because IGRA has increased specificity for TB infection in persons vaccinated with BCG, IGRA is preferred over the TST in these persons. Most persons born outside the United States have been vaccinated with BCG.

Previous or inactive tuberculosis

Chest radiograph findings consistent with previous or inactive TB include fibrosis or non-calcified nodules, but do not include a solitary calcified nodule or isolated pleural thickening. Persons with a previous chest radiograph showing findings consistent with previous or inactive TB should be tested for LTBI. In addition to LTBI testing, evaluate for active TB disease.

Negative test for LTBI does not rule out active TB disease

It is important to remember that a negative TST or IGRA result does not rule out active TB disease. In fact, a negative TST or IGRA in a patient with active TB disease can be a sign of extensive disease and poor outcome.

Symptoms that should trigger evaluation for active TB disease

Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB disease: cough for more than 2-3 weeks, fevers, night sweats, weight loss, and hemoptysis.

How to evaluate for active TB disease

Evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease

Most patients with LTBI should be treated

Persons with risk factors who test positive for LTBI should generally be treated once active TB disease has been ruled out. However, clinicians should not feel compelled to treat persons who have no risk factors but have a positive test for LTBI.

Emphasis on short course for treatment of LTBI

Shorter regimens for treating latent TB infection have been shown to be as effective as 9 months of isoniazid, and are more likely to be completed. Use of these shorter regimens is preferred in most patients. Drug-drug interactions and contact to drug resistant TB are typical reasons these regimens cannot be used.

Shorter duration LTBI treatment regimens

Medication	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + rifapentine	Weekly	12 weeks*

* 11-12 doses in 16 weeks required for completion.

Patient refusal of recommended LTBI treatment

Refusal should be documented. Recommendations for treatment should be made at future encounters with medical services. If treatment is later accepted, TB disease should be excluded and CXR repeated if it has been more than 6 months from the initial evaluation; or more than 3 months if there is immunosuppression, or the prior CXR was abnormal and consistent with potentially active TB disease.

Resources

Fact Sheets for LTBI Regimens, Isoniazid+Rifapentine, Rifampin, and Isoniazid are available on the TBCB LTBI Treatment page. (www.cdph.ca.gov/LTBITreatment)

U.S. Preventive Services Task Force Latent TB Infection Screening Recommendations are available on the U.S. Preventive Services Task Force website. (https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/latent-tuberculosis-infection-screening)

Abbreviations

AFB= acid-fast bacilli BCG= Bacillus Calmette-Guérin
CXR= chest x-ray DOT= directly observed therapy
IGRA=interferon gamma release assay LTBI= latent TB infection
MDR =multiple drug resistant NAAT= nucleic acid amplification testing
SAT= self-administered therapy TST= tuberculin skin test

Adult TB (Tuberculosis) Risk Assessment
Evaluando el Riesgo de Poder Contraer "TB" (Tuberculosis)

*** You may be at increased risk for TB if you answer YES to any of the following questions:** *** Sus hijos pueden tener un riesgo muy alto de poder contraer "TB" si contesta en informa afirmativa a cualquiera de las siguientes preguntas:**	Date / Fecha / /	Date / Fecha / /	Date / Fecha / /	Date / Fecha / /
1. Do you have a family member or close contact with history of confirmed or suspected TB? Existe algun contacto cercano o algun miembro de la familia que haya sido declardo enfermo de TB o que se sospeche tener esta enfermedad?	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐
2. Are you from Asia, Africa, Central America or South America? (These areas have a higher prevalence of TB.) Cuando emigraron a este pais lo hicieron de Asia, Africa, America Central de Sudamerica? (en estas reginoes del mundo existe un porcentaje muy alto de este enfermedad)	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐
3. Do you live in an "out of home" placement facility? Acaso ested se encuentra viviendo temporalmente en un hogar o local sostenido por el gobierño o asistencia social?	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐
4. Do you have a history of confirmed or suspected HIV infection? Acaso este haya sido, diagnosticado(a) con algun tipo de infeccion como el sida?	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐
5. Do you live with any individual who is HIV positive? Acaso ested haya sido declardo positivo con el examen del sida?	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐
6. Have you been, or do you live with any individual who has been incarcerated in the last 5 years? Acaso ested vive con adultos que hayan estado presos or cualquier motivo en los ultimos 5 anos?	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐
7. Do you live among, or are you frequently exposed to individuals who are homeless, migrant farm workers, users of street drugs, or resident in a nursing home? Acaso ested vive o se asocia frecuentemente con personas que viven en las calles, que sean trabajadores temporales del campo, utilicen drogas ilicitas inyectables o que residan en asilos o en hospitals de convalescencia?	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐	Yes/ Si ☐ No ☐

* A person who is at increased risk for TB should have a yearly TB test.
*Cualquir persona que tiene un alto riesgo de contraer /tb debe hacerse el examen de la tuberculosis cara año,

Name / Nombre:_____ Date/ Fecha:_____

Recommended Adult Immunization Schedule
for ages 19 years or older

UNITED STATES
2023

How to use the adult immunization schedule

1 Determine recommended vaccinations by age **(Table 1)**

2 Assess need for additional recommended vaccinations by medical condition or other indication **(Table 2)**

3 Review vaccine types, dosing frequencies and intervals, and considerations for special situations **(Notes)**

4 Review contraindications and precautions for vaccine types **(Appendix)**

Vaccines in the Adult Immunization Schedule*

Vaccine	Abbreviation(s)	Trade name(s)
COVID-19 vaccine	1vCOV-mRNA	Comirnaty®/Pfizer-BioNTech COVID-19 Vaccine SPIKEVAX®/Moderna COVID-19 Vaccine
	2vCOV-mRNA	Pfizer-BioNTech COVID-19 Vaccine, Bivalent Moderna COVID-19 Vaccine, Bivalent
	1vCOV-aPS	Novavax COVID-19 Vaccine
Haemophilus influenzae type b vaccine	Hib	ActHIB® Hiberix® PedvaxHIB®
Hepatitis A vaccine	HepA	Havrix® Vaqta®
Hepatitis A and hepatitis B vaccine	HepA-HepB	Twinrix®
Hepatitis B vaccine	HepB	Engerix-B® Heplisav-B® PreHevbrio® Recombivax HB®
Human papillomavirus vaccine	HPV	Gardasil 9®
Influenza vaccine (inactivated)	IIV4	Many brands
Influenza vaccine (live, attenuated)	LAIV4	FluMist® Quadrivalent
Influenza vaccine (recombinant)	RIV4	Flublok® Quadrivalent
Measles, mumps, and rubella vaccine	MMR	M-M-R II® Priorix®
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D MenACWY-CRM MenACWY-TT	Menactra® Menveo® MenQuadfi®
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero® Trumenba®
Pneumococcal conjugate vaccine	PCV15 PCV20	Vaxneuvance™ Prevnar 20™
Pneumococcal polysaccharide vaccine	PPSV23	Pneumovax 23®
Poliovirus vaccine	IPV	IPOL®
Tetanus and diphtheria toxoids	Td	Tenivac® Tdvax™
Tetanus and diphtheria toxoids and acellular pertussis vaccine	Tdap	Adacel® Boostrix®
Varicella vaccine	VAR	Varivax®
Zoster vaccine, recombinant	RZV	Shingrix

*Administer recommended vaccines if vaccination history is incomplete or unknown. Do not restart or add doses to vaccine series if there are extended intervals between doses. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American College of Physicians (www.acponline.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), American College of Nurse-Midwives (www.midwife.org), American Academy of Physician Associates (www.aapa.org), American Pharmacists Association (www.pharmacist.com), and Society for Healthcare Epidemiology of America (www.shea-online.org).

Report
- Suspected cases of reportable vaccine-preventable diseases or outbreaks to the local or state health department
- Clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System at www.vaers.hhs.gov or 800-822-7967

Injury claims
All vaccines included in the adult immunization schedule except PPSV23, RZV, and COVID-19 vaccines are covered by the National Vaccine Injury Compensation Program (VICP). COVID-19 vaccines that are authorized or approved by the FDA are covered by the Countermeasures Injury Compensation Program (CICP). For more information, see www.hrsa.gov/vaccinecompensation or www.hrsa.gov/cicp.

Questions or comments
Contact www.cdc.gov/cdc-info or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays.

Download the CDC Vaccine Schedules app for providers at www.cdc.gov/vaccines/schedules/hcp/schedule-app.html.

Helpful information
- Complete Advisory Committee on Immunization Practices (ACIP) recommendations: www.cdc.gov/vaccines/hcp/acip-recs/index.html
- *General Best Practice Guidelines for Immunization* (including contraindications and precautions): www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Vaccine information statements: www.cdc.gov/vaccines/hcp/vis/index.html
- Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response): www.cdc.gov/vaccines/pubs/surv-manual
- Travel vaccine recommendations: www.cdc.gov/travel
- Recommended Child and Adolescent Immunization Schedule, United States, 2023: www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html
- ACIP Shared Clinical Decision-Making Recommendations: www.cdc.gov/vaccines/acip/acip-scdm-faqs.html

Scan QR code for access to online schedule

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS310021-C

Table 1 Recommended Adult Immunization Schedule by Age Group, United States, 2023

Vaccine	19–26 years	27–49 years	50–64 years	≥65 years
COVID-19	2- or 3- dose primary series and booster (See Notes)			
Influenza inactivated (IIV4) or **Influenza recombinant** (RIV4)	1 dose annually			
or	or			
Influenza live, attenuated (LAIV4)	1 dose annually			
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap each pregnancy; 1 dose Td/Tdap for wound management (see notes)			
	1 dose Tdap, then Td or Tdap booster every 10 years			
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (if born in 1957 or later)			For healthcare personnel, see notes
Varicella (VAR)	2 doses (if born in 1980 or later)	2 doses		
Zoster recombinant (RZV)	2 doses for immunocompromising conditions (see notes)		2 doses	
Human papillomavirus (HPV)	2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years		
Pneumococcal (PCV15, PCV20, PPSV23)	1 dose PCV15 followed by PPSV23 OR 1 dose PCV20 (see notes)			See Notes
				See Notes
Hepatitis A (HepA)	2, 3, or 4 doses depending on vaccine			
Hepatitis B (HepB)	2, 3, or 4 doses depending on vaccine or condition			
Meningococcal A, C, W, Y (MenACWY)	1 or 2 doses depending on indication, see notes for booster recommendations			
Meningococcal B (MenB)	2 or 3 doses depending on vaccine and indication, see notes for booster recommendations			
	19 through 23 years			
***Haemophilus influenzae* type b** (Hib)	1 or 3 doses depending on indication			

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection

Recommended vaccination for adults with an additional risk factor or another indication

Recommended vaccination based on shared clinical decision-making

No recommendation/ Not applicable

Table 2 Recommended Adult Immunization Schedule by Medical Condition or Other Indication, United States, 2023

Vaccine	Pregnancy	Immuno-compromised (excluding HIV infection)	HIV infection CD4 percentage and count		Asplenia, complement deficiencies	End-stage renal disease, or on hemodialysis	Heart or lung disease; alcoholism[a]	Chronic liver disease	Diabetes	Health care personnel[b]	Men who have sex with men
			<15% or <200 mm³	≥15% and ≥200 mm³							
COVID-19		See Notes									
IIV4 or RIV4	1 dose annually										
or										or	
LAIV4	Contraindicated					Precaution				1 dose annually	
Tdap or Td	1 dose Tdap each pregnancy	1 dose Tdap, then Td or Tdap booster every 10 years									
MMR	Contraindicated*	Contraindicated		1 or 2 doses depending on indication							
VAR	Contraindicated*	Contraindicated			2 doses						
RZV		2 doses at age ≥19 years			2 doses at age ≥50 years						
HPV	Not Recommended*	3 doses through age 26 years			2 or 3 doses through age 26 years depending on age at initial vaccination or condition						
Pneumococcal (PCV15, PCV20, PPSV23)		1 dose PCV15 followed by PPSV23 OR 1 dose PCV20 (see notes)									
HepA					2, 3, or 4 doses depending on vaccine						
HepB	3 doses (see notes)	2, 3, or 4 doses depending on vaccine or condition									
MenACWY	1 or 2 doses depending on indication, see notes for booster recommendations										
MenB	Precaution	2 or 3 doses depending on vaccine and indication, see notes for booster recommendations									
Hib		3 doses HSCT[c] recipients only			1 dose						

- Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection
- Recommended vaccination for adults with an additional risk factor or another indication
- Recommended vaccination based on shared clinical decision-making
- Precaution–vaccination might be indicated if benefit of protection outweighs risk of adverse reaction
- Contraindicated or not recommended–vaccine should not be administered.

*Vaccinate after pregnancy.

- No recommendation/ Not applicable

a. Precaution for LAIV4 does not apply to alcoholism. **b.** See notes for influenza; hepatitis B; measles, mumps, and rubella; and varicella vaccinations. **c.** Hematopoietic stem cell transplant.

Notes

Recommended Adult Immunization Schedule for ages 19 years or older, United States, 2023

For vaccine recommendations for persons 18 years of age or younger, see the Recommended Child and Adolescent Immunization Schedule.

COVID-19 vaccination

Routine vaccination

- **Primary series:** 2-dose series at 0, 4-8 weeks (Moderna) or 2-dose series at 0, 3-8 weeks (Novavax, Pfizer-BioNTech)
- **Booster dose:** see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html

Special situations

Persons who are moderately or severely immunocompromised

- **Primary series**
  - 3-dose series at 0, 4, 8 weeks (Moderna) or 3-dose series at 0, 3, 7 weeks (Pfizer-BioNTech)
  - 2-dose series at 0, 3 weeks (Novavax)
- **Booster dose:** see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html
- **Pre-exposure prophylaxis (e.g., monoclonal antibodies)** may be considered to complement COVID-19 vaccination. See www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#immunocompromised

For Janssen COVID-19 Vaccine recipients see COVID-19 schedule at www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html.

Note: Current COVID-19 schedule available at www.cdc.gov/vaccines/covid-19/downloads/COVID-19-immunization-schedule-ages-6months-older.pdf. For more information on Emergency Use Authorization (EUA) indications for COVID-19 vaccines, please visit www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines

Haemophilus influenzae type b vaccination

Special situations

- **Anatomical or functional asplenia (including sickle cell disease):** 1 dose if previously did not receive Hib; if elective splenectomy, 1 dose preferably at least 14 days before splenectomy
- **Hematopoietic stem cell transplant (HSCT):** 3-dose series 4 weeks apart starting 6–12 months after successful transplant, regardless of Hib vaccination history

Hepatitis A vaccination

Routine vaccination

- **Not at risk but want protection from hepatitis A** (identification of risk factor not required): 2-dose series HepA (Havrix 6–12 months apart or Vaqta 6–18 months apart [minimum interval: 6 months]) or 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months])

Special situations

- **At risk for hepatitis A virus infection:** 2-dose series HepA or 3-dose series HepA-HepB as above
  - **Chronic liver disease** (e.g., persons with hepatitis B, hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice the upper limit of normal)
  - **HIV infection**
  - **Men who have sex with men**
  - **Injection or noninjection drug use**
  - **Persons experiencing homelessness**
  - **Work with hepatitis A virus** in research laboratory or with nonhuman primates with hepatitis A virus infection
  - **Travel in countries with high or intermediate endemic hepatitis A** (HepA-HepB [Twinrix] may be administered on an accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months)
  - **Close, personal contact with international adoptee** (e.g., household or regular babysitting) in first 60 days after arrival from country with high or intermediate endemic hepatitis A (administer dose 1 as soon as adoption is planned, at least 2 weeks before adoptee's arrival)
  - **Pregnancy** if at risk for infection or severe outcome from infection during pregnancy
  - **Settings for exposure,** including health care settings targeting services to injection or noninjection drug users or group homes and nonresidential day care facilities for developmentally disabled persons (individual risk factor screening not required)

Hepatitis B vaccination

Routine vaccination

- **Age 19 through 59 years: complete a 2- or 3- or 4-dose series**
  - 2-dose series only applies when 2 doses of Heplisav-B* are used at least 4 weeks apart
  - 3-dose series Engerix-B, PreHevbrio*, or Recombivax HB at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks])
  - 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months])
  - 4-dose series HepA-HepB (Twinrix) accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months

*__Note:__ Heplisav-B and PreHevbrio are not recommended in pregnancy due to lack of safety data in pregnant persons.

Notes

- **Age 60 years or older with** known risk factors for hepatitis B virus infection **should** complete a HepB vaccine series.
- **Age 60 years or older without** known risk factors for hepatitis B virus infection **may** complete a HepB vaccine series.
  - **Risk factors for hepatitis B virus infection include:**
    - **Chronic liver disease** (e.g., persons with hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice upper limit of normal)
    - **HIV infection**
    - **Sexual exposure risk** (e.g., sex partners of hepatitis B surface antigen [HBsAg]-positive persons; sexually active persons not in mutually monogamous relationships; persons seeking evaluation or treatment for a sexually transmitted infection; men who have sex with men)
    - **Current or recent injection drug use**
    - **Percutaneous or mucosal risk for exposure to blood** (e.g., household contacts of HBsAg-positive persons; residents and staff of facilities for developmentally disabled persons; health care and public safety personnel with reasonably anticipated risk for exposure to blood or blood-contaminated body fluids; persons on maintenance dialysis, including in-center or home hemodialysis and peritoneal dialysis, and persons who are predialysis; patients with diabetes)
    - **Incarceration**
    - **Travel in countries with high or intermediate endemic hepatitis B**

Special situations

- **Patients on dialysis:** complete a 3- or 4-dose series
  - 3-dose series Recombivax HB at 0, 1, 6 months (note: use Dialysis Formulation 1 mL = 40 mcg)
  - 4-dose series Engerix-B at 0, 1, 2, and 6 months (note: use 2 mL dose instead of the normal adult dose of 1 mL)

Human papillomavirus vaccination

Routine vaccination

- **HPV vaccination recommended for all persons through age 26 years:** 2- or 3-dose series depending on age at initial vaccination or condition:
  - **Age 15 years or older at initial vaccination:** 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)
  - **Age 9–14 years at initial vaccination and received 1 dose or 2 doses less than 5 months apart:** 1 additional dose
  - **Age 9–14 years at initial vaccination and received 2 doses at least 5 months apart:** HPV vaccination series complete, no additional dose needed
- **Interrupted schedules:** If vaccination schedule is interrupted, the series does not need to be restarted
- **No additional dose recommended when any HPV vaccine series has been completed using the recommended dosing intervals.**

Shared clinical decision-making

- **Some adults age 27–45 years:** Based on shared clinical decision-making, 2- or 3-dose series as above

Special situations

- **Age ranges recommended above for routine and catch-up vaccination or shared clinical decision-making also apply in special situations**
  - **Immunocompromising conditions, including HIV infection**: 3-dose series, even for those who initiate vaccination at age 9 through 14 years.
  - **Pregnancy**: Pregnancy testing is not needed before vaccination; HPV vaccination is not recommended until after pregnancy; no intervention needed if inadvertently vaccinated while pregnant

Influenza vaccination

Routine vaccination

- **Age 19 years or older:** 1 dose any influenza vaccine appropriate for age and health status annually.
  - **Age 65 years or older:** Any one of quadrivalent high-dose inactivated influenza vaccine (HD-IIV4), quadrivalent recombinant influenza vaccine (RIV4), or quadrivalent adjuvanted inactivated influenza vaccine (aIIV4) is preferred. If none of these three vaccines is available, then any other age-appropriate influenza vaccine should be used.
- For the 2022–2023 season, see www.cdc.gov/mmwr/volumes/71/rr/rr7101a1.htm
- For the 2023–2024 season, see the 2023–2024 ACIP influenza vaccine recommendations.

Special situations

- **Egg allergy, hives only:** any influenza vaccine appropriate for age and health status annually
- **Egg allergy–any symptom other than hives** (e.g., angioedema, respiratory distress or required epinephrine or another emergency medical intervention): Any influenza vaccine appropriate for age and health status may be administered. If using egg-based IIV4 or LAIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions.
- **Close contacts (e.g., caregivers, healthcare workers) of severely immunosuppressed persons who require a protected environment:** these persons should not receive LAIV4. If LAIV4 is given, they should avoid contact with/caring for such immunosuppressed persons for 7 days after vaccination.
- **Severe allergic reaction (e.g., anaphylaxis) to a vaccine component or a previous dose of any influenza vaccine:** see Appendix listing contraindications and precautions

Notes Recommended Adult Immunization Schedule, United States, 2023

- **History of Guillain-Barré syndrome within 6 weeks after previous dose of influenza vaccine:** Generally, should not be vaccinated unless vaccination benefits outweigh risks for those at higher risk for severe complications from influenza

Measles, mumps, and rubella vaccination

Routine vaccination

- **No evidence of immunity to measles, mumps, or rubella:** 1 dose
  - **Evidence of immunity:** Born before 1957 (health care personnel, see below), documentation of receipt of MMR vaccine, laboratory evidence of immunity or disease (diagnosis of disease without laboratory confirmation is not evidence of immunity)

Special situations

- **Pregnancy with no evidence of immunity to rubella:** MMR contraindicated during pregnancy; after pregnancy (before discharge from health care facility), 1 dose
- **Nonpregnant persons of childbearing age with no evidence of immunity to rubella:** 1 dose
- **HIV infection with CD4 percentages ≥15% and CD4 count ≥200 cells/mm³ for at least 6 months and no evidence of immunity to measles, mumps, or rubella:** 2-dose series at least 4 weeks apart; MMR contraindicated for HIV infection with CD4 percentage <15% or CD4 count <200 cells/mm³
- **Severe immunocompromising conditions:** MMR contraindicated
- **Students in postsecondary educational institutions, international travelers, and household or close, personal contacts of immunocompromised persons with no evidence of immunity to measles, mumps, or rubella:** 2-dose series at least 4 weeks apart if previously did not receive any doses of MMR or 1 dose if previously received 1 dose MMR
- **In mumps outbreak settings,** for information about additional doses of MMR (including 3rd dose of MMR), see www.cdc.gov/mmwr/volumes/67/wr/mm6701a7.htm
- **Health care personnel:**
  - **Born before 1957 with no evidence of immunity to measles, mumps, or rubella:** Consider 2-dose series at least 4 weeks apart for protection against measles or mumps or 1 dose for protection against rubella
  - **Born in 1957 or later with no evidence of immunity to measles, mumps, or rubella:** 2-dose series at least 4 weeks apart for protection against measles or mumps or at least 1 dose for protection against rubella

Meningococcal vaccination

Special situations for MenACWY

- **Anatomical or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:** 2-dose series MenACWY-D (Menactra, Menveo, or MenQuadfi) at least 8 weeks apart and revaccinate every 5 years if risk remains
- **Travel in countries with hyperendemic or epidemic meningococcal disease, or microbiologists routinely exposed to *Neisseria meningitidis*:** 1 dose MenACWY (Menactra, Menveo, or MenQuadfi) and revaccinate every 5 years if risk remains
- **First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits:** 1 dose MenACWY (Menactra, Menveo, or MenQuadfi)
- For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting (e.g., in community or organizational settings and among men who have sex with men) and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm

Shared clinical decision-making for MenB

- **Adolescents and young adults age 16–23 years (age 16–18 years preferred) not at increased risk for meningococcal disease:** Based on shared clinical decision-making, 2-dose series MenB-4C (Bexsero) at least 1 month apart or 2-dose series MenB-FHbp (Trumenba) at 0, 6 months (if dose 2 was administered less than 6 months after dose 1, administer dose 3 at least 4 months after dose 2); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series)

Special situations for MenB

- **Anatomical or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use, or microbiologists routinely exposed to *Neisseria meningitidis*:** 2-dose primary series MenB-4C (Bexsero) at least 1 month apart or 3-dose primary series MenB-FHbp (Trumenba) at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed; if dose 3 is administered earlier than 4 months after dose 2, a fourth dose should be administered at least 4 months after dose 3); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series); 1 dose MenB booster 1 year after primary series and revaccinate every 2–3 years if risk remains
- **Pregnancy:** Delay MenB until after pregnancy unless at increased risk and vaccination benefits outweigh potential risks
- For MenB **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting (e.g., in community or organizational settings and among men who have sex with men) and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm

Note: MenB vaccines may be administered simultaneously with MenACWY vaccines if indicated, but at a different anatomic site, if feasible.

Notes

Pneumococcal vaccination

Routine vaccination

- **Age 65 years or older who have:**
  - **Not previously received a dose of PCV13, PCV15, or PCV20 or whose previous vaccination history is unknown:** 1 dose PCV15 OR 1 dose PCV20. If PCV15 is used, this should be followed by a dose of PPSV23 given at least 1 year after the PCV15 dose. A minimum interval of 8 weeks between PCV15 and PPSV23 can be considered for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak to minimize the risk of invasive pneumococcal disease caused by serotypes unique to PPSV23 in these vulnerable groups.
  - **Previously received only PCV7:** follow the recommendation above.
  - **Previously received only PCV13:** 1 dose PCV20 at least 1 year after the PCV13 dose OR complete the recommended PPSV23 series as described here www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf.
  - **Previously received only PPSV23:** 1 dose PCV15 OR 1 dose PCV20 at least 1 year after the PPSV23 dose. If PCV15 is used, it need not be followed by another dose of PPSV23.
  - **Previously received both PCV13 and PPSV23 but NO PPSV23 was received at age 65 years or older:** 1 dose PCV20 at least 5 years after their last pneumococcal vaccine dose OR complete the recommended PPSV23 series as described here www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf.
  - **Previously received both PCV13 and PPSV23, AND PPSV23 was received at age 65 years or older:** Based on shared clinical decision-making, 1 dose of PCV20 at least 5 years after the last pneumococcal vaccine dose.
- For guidance on determining which pneumococcal vaccines a patient needs and when, please refer to the mobile app which can be downloaded here: www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumoapp.html

Special situations

- **Age 19–64 years with certain underlying medical conditions or other risk factors** who have**
  - **Not previously received a PCV13, PCV15, or PCV20 or whose previous vaccination history is unknown:** 1 dose PCV15 OR 1 dose PCV20. If PCV15 is used, this should be followed by a dose of PPSV23 given at least 1 year after the PCV15 dose. A minimum interval of 8 weeks between PCV15 and PPSV23 can be considered for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak
  - **Previously received only PCV7:** follow the recommendation above.
  - **Previously received only PCV13:** 1 dose PCV20 at least 1 year after the PCV13 dose OR complete the recommended PPSV23 series as described here www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf.
  - **Previously received only PPSV23:** 1 dose PCV15 OR 1 dose PCV20 at least 1 year after the PPSV23 dose. If PCV15 is used, it need not be followed by another dose of PPSV23.
  - **Previously received both PCV13 and PPSV23 but have not completed the recommended series:** 1 dose PCV20 at least 5 years after their last pneumococcal vaccine dose OR complete the recommended PPSV23 series as described here www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf.
- For guidance on determining which pneumococcal vaccines a patient needs and when, please refer to the mobile app which can be downloaded here: www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumoapp.html

*__Note:__ Immunocompromising conditions include chronic renal failure, nephrotic syndrome, immunodeficiency, iatrogenic immunosuppression, generalized malignancy, human immunodeficiency virus, Hodgkin disease, leukemia, lymphoma, multiple myeloma, solid organ transplants, congenital or acquired asplenia, sickle cell disease, or other hemoglobinopathies.

**__Note:__ Underlying medical conditions or other risk factors include alcoholism, chronic heart/liver/lung disease, chronic renal failure, cigarette smoking, cochlear implant, congenital or acquired asplenia, CSF leak, diabetes mellitus, generalized malignancy, HIV, Hodgkin disease, immunodeficiency, iatrogenic immunosuppression, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, solid organ transplants, or sickle cell disease or other hemoglobinopathies.

Polio vaccination

Routine vaccination

Routine poliovirus vaccination of adults residing in the United States is not necessary.

Special situations

- **Adults at increased risk of exposure to poliovirus with:**
  - No evidence of a complete polio vaccination series (i.e., at least 3 doses): administer remaining doses (1, 2, or 3 doses) to complete a 3-dose series
  - Evidence of completed polio vaccination series (i.e., at least 3 doses): may administer one lifetime IPV booster

For detailed information, see: www.cdc.gov/vaccines/vpd/polio/hcp/recommendations.html

Notes Recommended Adult Immunization Schedule, United States, 2023

Tetanus, diphtheria, and pertussis vaccination

Routine vaccination

- **Previously did not receive Tdap at or after age 11 years:** 1 dose Tdap, then Td or Tdap every 10 years

Special situations

- **Previously did not receive primary vaccination series for tetanus, diphtheria, or pertussis:** 1 dose Tdap followed by 1 dose Td or Tdap at least 4 weeks later, and a third dose of Td or Tdap 6–12 months later (Tdap can be substituted for any Td dose, but preferred as first dose), Td or Tdap every 10 years thereafter
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- **Wound management:** Persons with 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant woman, use Tdap. For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm

Varicella vaccination

Routine vaccination

- **No evidence of immunity to varicella:** 2-dose series 4–8 weeks apart if previously did not receive varicella-containing vaccine (VAR or MMRV [measles-mumps-rubella-varicella vaccine] for children); if previously received 1 dose varicella-containing vaccine, 1 dose at least 4 weeks after first dose
  - **Evidence of immunity:** U.S.-born before 1980 (except for pregnant persons and health care personnel [see below]), documentation of 2 doses varicella-containing vaccine at least 4 weeks apart, diagnosis or verification of history of varicella or herpes zoster by a health care provider, laboratory evidence of immunity or disease

Special situations

- **Pregnancy with no evidence of immunity to varicella:** VAR contraindicated during pregnancy; after pregnancy (before discharge from health care facility), 1 dose if previously received 1 dose varicella-containing vaccine or dose 1 of 2-dose series (dose 2: 4–8 weeks later) if previously did not receive any varicella-containing vaccine, regardless of whether U.S.-born before 1980
- **Health care personnel with no evidence of immunity to varicella:** 1 dose if previously received 1 dose varicella-containing vaccine; 2-dose series 4–8 weeks apart if previously did not receive any varicella-containing vaccine, regardless of whether U.S.-born before 1980
- **HIV infection with CD4 percentages ≥15% and CD4 count ≥200 cells/mm^3 with no evidence of immunity:** Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with CD4 percentage <15% or CD4 count <200 cells/mm^3
- **Severe immunocompromising conditions:** VAR contraindicated

Zoster vaccination

Routine vaccination

- **Age 50 years or older*:** 2-dose series recombinant zoster vaccine (RZV, Shingrix) 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon), regardless of previous herpes zoster or history of zoster vaccine live (ZVL, Zostavax) vaccination.

***Note:** Serologic evidence of prior varicella is not necessary for zoster vaccination. However, if serologic evidence of varicella susceptibility becomes available, providers should follow ACIP guidelines for varicella vaccination first. RZV is not indicated for the prevention of varicella, and there are limited data on the use of RZV in persons without a history of varicella or varicella vaccination.

Special situations

- **Pregnancy:** There is currently no ACIP recommendation for RZV use in pregnancy. Consider delaying RZV until after pregnancy.
- **Immunocompromising conditions (including persons with HIV regardless of CD4 count)**:** 2-dose series recombinant zoster vaccine (RZV, Shingrix) 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon). For detailed information, see www.cdc.gov/shingles/vaccination/immunocompromised-adults.html

****Note:** If there is no documented history of varicella, varicella vaccination, or herpes zoster, providers should refer to the clinical considerations for use of RZV in immunocompromised adults aged ≥19 years and the ACIP varicella vaccine recommendations for further guidance: www.cdc.gov/mmwr/volumes/71/wr/mm7103a2.htm

Appendix Recommended Adult Immunization Schedule, United States, 2023

Guide to Contraindications and Precautions to Commonly Used Vaccines

Adapted from Table 4-1 in Advisory Committee on Immunization Practices (ACIP) General Best Practice Guidelines for Immunization: Contraindication and Precautions available at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html *and ACIP's Recommendations for the Prevention and Control of 2022-23 Seasonal Influenza with Vaccines available at www.cdc.gov/mmwr/volumes/71/rr/rr7101a1.htm*

For COVID-19 vaccine contraindications and precautions see
www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#contraindications

Vaccine	Contraindicated or Not Recommended[1]	Precautions[2]
Influenza, egg-based, inactivated injectable (IIV4)	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg)	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Moderate or severe acute illness with or without fever
Influenza, cell culture-based inactivated injectable [(ccIIV4), Flucelvax® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any ccIIV of any valency, or to any component[3] of ccIIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, RIV, or LAIV of any valency. If using ccIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, recombinant injectable [(RIV4), Flublok® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component[3] of RIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, ccIIV, or LAIV of any valency. If using RIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, live attenuated [LAIV4, Flumist® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg) • Anatomic or functional asplenia • Immunocompromised due to any cause including, but not limited to, medications and HIV infection • Close contacts or caregivers of severely immunosuppressed persons who require a protected environment • Pregnancy • Cochlear implant • Active communication between the cerebrospinal fluid (CSF) and the oropharynx, nasopharynx, nose, ear, or any other cranial CSF leak • Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days.	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Asthma in persons aged 5 years old or older • Persons with underlying medical conditions (other than those listed under contraindications) that might predispose to complications after wild-type influenza virus infection [e.g., chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus)] • Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.

Appendix Recommended Adult Immunization Schedule, United States, 2023

Vaccine	Contraindicated or Not Recommended[1]	Precautions[2]
Haemophilus influenzae type b (Hib)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Hiberix, ActHib, and PedvaxHIB only: History of severe allergic reaction to dry natural latex	• Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin	• Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including yeast • *Pregnancy: Heplisav-B and PreHevbrio are not recommended due to lack of safety data in pregnant persons. Use other hepatitis B vaccines if HepB is indicated*[4]	• Moderate or severe acute illness with or without fever
Hepatitis A- Hepatitis B vaccine [HepA-HepB, (Twinrix®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin and yeast	• Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • *Pregnancy: HPV vaccination not recommended*	• Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • History of thrombocytopenia or thrombocytopenic purpura • Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing • Moderate or severe acute illness with or without fever
Meningococcal ACWY (MenACWY) [MenACWY-CRM (Menveo®); MenACWY-D (Menactra®); MenACWY-TT (MenQuadfi®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For MenACWY-D and MenACWY-CRM only: severe allergic reaction to any diphtheria toxoid–or CRM197–containing vaccine • For MenACWY-TT only: severe allergic reaction to a tetanus toxoid-containing vaccine	• Moderate or severe acute illness with or without fever
Meningococcal B (MenB) [MenB-4C (Bexsero); MenB-FHbp (Trumenba)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Pregnancy • For MenB-4C only: Latex sensitivity • Moderate or severe acute illness with or without fever
Pneumococcal conjugate (PCV15, PCV20)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxoid–containing vaccine or to its vaccine component[3]	• Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Tetanus, diphtheria, and acellular pertussis (Tdap) Tetanus, diphtheria (Td)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Tdap only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures), not attributable to another identifiable cause, within 7 days of administration of previous dose of DTP, DTaP, or Tdap	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus-toxoid–containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid–containing or tetanus-toxoid–containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid–containing vaccine • Moderate or severe acute illness with or without fever • For Tdap only: Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized
Varicella (VAR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination) • Use of aspirin or aspirin-containing products • Moderate or severe acute illness with or without fever
Zoster recombinant vaccine (RZV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever • Current herpes zoster infection

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.
4. For information on the pregnancy exposure registries for persons who were inadvertently vaccinated with Heplisav-B or PreHevbrio while pregnant, please visit heplisavbpregnancyregistry.com/ or www.prehevbrio.com/#safety.

Vaccine Administration Record for Adults

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Patient name_____

Birthdate_____ Chart number_____

PRACTICE NAME AND ADDRESS

Vaccine	Type of Vaccine[1]	Date vaccine given (mo/day/yr)	Funding Source (F,S,P)[2]	Route[3] and Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[5] (signature or initials and title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Tetanus, Diphtheria, Pertussis (e.g., Tdap, Td) Give IM.[3]									
Hepatitis A (e.g., HepA, HepA-HepB[6]) Give IM.[3]									
Hepatitis B[1] (e.g., Engerix-B, Recombivax HB, Heplisav-B, HepA-HepB[6]) Give IM.[3]									
Human papillomavirus (HPV2*, HPV4*, HPV9) Give IM.[3]									
Measles, Mumps, Rubella (MMR) Give Subcut.[3]									
Varicella (chickenpox,VAR) Give Subcut.[3]									
Meningococcal ACWY (e.g., MenACWY, MPSV4*) Give MenACWY IM.[3]									
Meningococcal B (e.g., MenB) Give MenB IM.[3]									

*HPV2, HPV4, and MPSV4 vaccines are no longer available in the U.S., but should be included in patient records for historical purposes.

▶ **See page 2** to record influenza, pneumococcal, zoster, Hib, and other vaccines (e.g., travel vaccines).

How to Complete this Record

1. With the exception of hepatitis B vaccines, record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine; for hepatitis B vaccines, record the trade name (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (Subcut [SC]), intradermal (ID), intranasal (NAS), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.
6. For combination vaccines, fill in a row for each antigen in the combination.

Abbreviation	Trade Name and Manufacturer
Tdap	Adacel (Sanofi Pasteur); Boostrix (GlaxoSmithKline [GSK])
Td	Decavac, Tenivac (Sanofi Pasteur); generic Td (MA Biological Labs)
HepA	Havrix (GSK); Vaqta (Merck)
For hepatitis B, see footnote #1.	Engerix-B (GSK); Recombivax HB (Merck); Heplisav-B (Dynavax)
HepA-HepB	Twinrix (GSK)
HPV2*	Cervarix (GSK)
HPV4*, HPV9	Gardasil, Gardasil 9 (Merck)
MMR	MMRII (Merck)
VAR	Varivax (Merck)
MenACWY	Menactra (Sanofi Pasteur); Menveo (GSK)
MPSV4*	Menomune (Sanofi Pasteur)
MenB	Bexsero (GSK); Trumenba (Pfizer)

CONTINUED ON THE NEXT PAGE ▶

Vaccine Administration Record for Adults (continued)

Patient name_____

Birthdate_____ Chart number_____

PRACTICE NAME AND ADDRESS

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccine	Type of Vaccine[1]	Date vaccine given (mo/day/yr)	Funding Source (F,S,P)[2]	Route[3] and Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[5] (signature or initials and title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Influenza (e.g., IIV3, IIV4, ccIIV4, RIV3, RIV4, LAIV4) Give IIV3, IIV4, ccIIV3, RIV3, and RIV4 IM.[3] Give LAIV4 NAS.[3]									
Pneumococcal conjugate (e.g., PCV13) Give PCV13 IM.[3]									
Pneumococcal polysaccharide (e.g., PPSV23) Give PPSV23 IM or Subcut.[3]									
Zoster (shingles) Give RZV IM[3] Give ZVL Subcut[3]									
Hib Give IM.[3]									
Other									

▶ **See page 1** to record Tdap/Td, hepatitis A, hepatitis B, HPV, MMR, varicella, MenACWY, and MenB vaccines.

How to Complete this Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (Subcut [SC]), intradermal (ID), intranasal (NAS), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.

Abbreviation	Trade Name and Manufacturer
IIV3/IIV4 (inactivated influenza vaccine, trivalent or quadrivalent); ccIIV4 (cell culture-based inactivated influenza vaccine, quadrivalent); RIV3/RIV4 (inactivated recombinant influenza vaccine, trivalent or quadrivalent)	Fluarix, FluLaval (GSK); Afluria, Fluad, Flucelvax, Fluvirin (Seqirus); Flublok, Fluzone, Fluzone Intradermal, Fluzone High-Dose (Sanofi Pasteur)
LAIV (live attenuated influenza vaccine, quadrivalent]	FluMist (MedImmune)
PCV13	Prevnar 13 (Pfizer)
PPSV23	Pneumovax 23 (Merck)
RZV (recombinant zoster vaccine) ZVL (zoster vaccine, live)	Shingrix, RZV (GSK); Zostavax, ZVL (Merck)
Hib	ActHIB (Sanofi Pasteur); Hiberix (GSK); PedvaxHib (Merck)

Vaccine Administration Record for Adults

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Patient name **Mike Schultz**

Birthdate **5/31/1967** Chart number **010406**

PRACTICE NAME AND ADDRESS

Small Rural Clinic
135 County Road 42
Smallville, IN 46902

Vaccine	Type of Vaccine[1]	Date vaccine given (mo/day/yr)	Funding Source (F,S,P)[2]	Route[3] and Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[5] (signature or initials and title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Tetanus, Diphtheria, Pertussis (e.g., Tdap, Td) Give IM.[3]	Td	8/1/02	P	IM/LA	U0376AA	AVP	6/10/94	8/1/02	JTA
	Td	9/1/02	P	IM/LA	U0376AA	AVP	6/10/94	9/1/02	RVO
	Td	3/1/03	P	IM/LA	U0376AA	AVP	3/1/03	3/1/03	TAA
	Tdap	3/1/15	P	IM/LA	AC52B009AA	GSK	2/24/15	3/1/15	JTA
Hepatitis A (e.g., HepA, HepA-HepB[6]) Give IM.[3]									
Hepatitis B[1] (e.g., Engerix-B, Recombivax HB, Heplisav-B, HepA-HepB[6]) Give IM.[3]	Heplisav-B	2/5/18	P	IM/LA	TDG007	DVX	7/20/16	2/5/18	TAA
	Heplisav-B	3/12/18	P	IM/LA	TDG007	DVX	7/20/16	3/12/18	TAA
Human papillomavirus (HPV2*, HPV4*, HPV9) Give IM.[3]									
Measles, Mumps, Rubella (MMR) Give Subcut.[3]	MMR	8/1/02	P	SC/RA	0025L	MSD	6/13/02	8/1/02	JTA
	MMR	11/1/02	P	SC/RA	0025L	MSD	6/13/02	11/1/02	TAA
Varicella (chickenpox,VAR) Give Subcut.[3]	VAR	8/1/02	P	SC/LA	0799M	MSD	12/16/98	8/1/02	JTA
	VAR	11/1/02	P	SC/LA	0799M	MSD	12/16/98	11/1/02	TAA
Meningococcal ACWY (e.g., MenACWY, MPSV4*) Give MenACWY IM.[3]	MenACWY	7/12/11	P	IM/RA	M28011	NOV	3/2/08	7/12/11	RVO
	Menveo	7/15/16	P	IM/LA	M12115	NOV	3/31/16	7/15/16	RVO
Meningococcal B (e.g., MenB) Give MenB IM.[3]	MenB	1/14/16	P	IM/LA	J296203	PFR	8/14/15	1/14/16	RVO
	Trumenba	9/15/16	P	IM/LA	J296203	PFR	8/14/15	9/15/16	RVO

*HPV2, HPV4, and MPSV4 vaccines are no longer available in the U.S., but should be included in patient records for historical purposes.

▶ **See page 2** to record influenza, pneumococcal, zoster, Hib, and other vaccines (e.g., travel vaccines).

How to Complete this Record

1. With the exception of hepatitis B vaccines, record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine; for hepatitis B vaccines, record the trade name (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (Subcut [SC]), intradermal (ID), intranasal (NAS), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.
6. For combination vaccines, fill in a row for each antigen in the combination.

Abbreviation	Trade Name and Manufacturer
Tdap	Adacel (Sanofi Pasteur); Boostrix (GlaxoSmithKline [GSK])
Td	Decavac, Tenivac (Sanofi Pasteur); generic Td (MA Biological Labs)
HepA	Havrix (GSK); Vaqta (Merck)
For hepatitis B, see footnote #1.	Engerix-B (GSK); Recombivax HB (Merck); Heplisav-B (Dynavax)
HepA-HepB	Twinrix (GSK)
HPV2*	Cervarix (GSK)
HPV4*, HPV9	Gardasil, Gardasil 9 (Merck)
MMR	MMRII (Merck)
VAR	Varivax (Merck)
MenACWY	Menactra (Sanofi Pasteur); Menveo (GSK)
MPSV4*	Menomune (Sanofi Pasteur)
MenB	Bexsero (GSK); Trumenba (Pfizer)

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Vaccine Administration Record for Adults (continued)

Patient name **Mike Schultz**

Birthdate **5/31/1967** Chart number **010406**

PRACTICE NAME AND ADDRESS

Small Rural Clinic
135 County Road 42
Smallville, IN 46902

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccine	Type of Vaccine[1]	Date vaccine given (mo/day/yr)	Funding Source (F,S,P)[2]	Route[3] and Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[5] (signature or initials and title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Influenza (e.g., IIV3, IIV4, ccIIV4, RIV3, RIV4, LAIV4) Give IIV3, IIV4, ccIIV3, RIV3, and RIV4 IM.[3] Give LAIV4 NAS.[3]	Flulaval	10/2/09	P	IM/RA	2F600411	GSK	8/11/09	10/2/09	PWS
	H1N1	12/7/09	P	IM/RA	10092224P	NOV	10/2/09	12/7/09	DLW
	Afluria	9/12/10	P	IM/RA	06949111A	NOV	8/10/10	9/12/10	TAA
	Flulaval	10/1/11	P	IM/LA	2F750345	GSK	8/10/11	10/1/11	JTA
	IIV3	9/5/12	P	IM/RA	M50907	CSL	7/2/12	9/5/12	KKC
	RIV3	12/2/13	P	IM/RA	350603F	PSC	7/26/13	12/2/13	DCP
	IIV4	10/5/14	P	IM/RA	U1196AA	PMC	8/19/14	10/5/14	JTA
	IIV4	11/2/15	P	IM/LA	123773P	NOV	8/7/15	11/2/15	DCP
	IIV4	10/1/16	P	IM/LA	U1206AA	PMC	8/7/15	10/1/16	TAA
	ccIIV4	9/30/17	P	IM/LA	185128	SEQ	8/7/15	9/30/17	RVO
Pneumococcal conjugate (e.g., PCV13) Give PCV13 IM.[3]	PCV13	11/1/12	P	IM/RA	7-5096-06A	WYE	4/16/10	11/1/12	CJP
Pneumococcal polysaccharide (e.g., PPSV23) Give PPSV23 IM or Subcut.[3]	PPSV23	9/12/10	P	IM/RA	663012/1163X	MSD	10/6/09	9/12/10	TAA
	PPSV23	11/2/15	P	IM/RA	663012/1163X	MSD	10/6/09	11/2/15	DCP
Zoster (shingles) Give RZV IM[3] Give ZVL Subcut[3]	RZV	3/15/18	P	IM/RA	A1283	GSK	2/12/18	3/15/18	CJP
	Shingrix	5/17/18	P	IM/RA	A1283	GSK	2/12/18	5/17/18	CJP
Hib Give IM.[3]	ActHIB	11/1/12	P	IM/RA	D05561	PMC	4/16/10	11/1/12	CJP
Other									

▶ **See page 1** to record Tdap/Td, hepatitis A, hepatitis B, HPV, MMR, varicella, MenACWY, and MenB vaccines.

How to Complete this Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (Subcut [SC]), intradermal (ID), intranasal (NAS), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.

Abbreviation	Trade Name and Manufacturer
IIV3/IIV4 (inactivated influenza vaccine, trivalent or quadrivalent); ccIIV4 (cell culture-based inactivated influenza vaccine, quadrivalent); RIV3/RIV4 (inactivated recombinant influenza vaccine, trivalent or quadrivalent)	Fluarix, FluLaval (GSK); Afluria, Fluad, Flucelvax, Fluvirin (Seqirus); Flublok, Fluzone, Fluzone Intradermal, Fluzone High-Dose (Sanofi Pasteur)
LAIV (live attenuated influenza vaccine, quadrivalent]	FluMist (MedImmune)
PCV13	Prevnar 13 (Pfizer)
PPSV23	Pneumovax 23 (Merck)
RZV (recombinant zoster vaccine) ZVL (zoster vaccine, live)	Shingrix, RZV (GSK); Zostavax, ZVL (Merck)
Hib	ActHIB (Sanofi Pasteur); Hiberix (GSK); PedvaxHib (Merck)

WHERE IS THE VIS DATE LOCATED?

ANSWER: The "VIS Date" is located at the bottom of the first OR second page of the Vaccine Information Statement (VIS) depending on the type of vaccine.

VACCINE INFORMATION STATEMENT

Tdap Vaccine

What You Need to Know

(Tetanus, Diphtheria and Pertussis)

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Tetanus, diphtheria and **pertussis** are very serious diseases. Tdap vaccine can protect us from these diseases. And, Tdap vaccine given to pregnant women can protect newborn babies against pertussis..

TETANUS (Lockjaw) is rare in the United States today. It causes painful muscle tightening and stiffness, usually all over the body.

- It can lead to tightening of muscles in the head and neck so you can't open your mouth, swallow, or sometimes even breathe. Tetanus kills about 1 out of 10 people who are infected even after receiving the best medical care.

DIPHTHERIA is also rare in the United States today. It can cause a thick coating to form in the back of the throat.

2 Tdap vaccine

Tdap vaccine can protect adolescents and adults from tetanus, diphtheria, and pertussis. One dose of Tdap is routinely given at age 11 or 12. People who did *not* get Tdap at that age should get it as soon as possible.

Tdap is especially important for healthcare professionals and anyone having close contact with a baby younger than 12 months.

Pregnant women should get a dose of Tdap during **every pregnancy**, to protect the newborn from pertussis. Infants are most at risk for severe, life-threatening complications from pertussis.

Another vaccine, called Td, protects against tetanus and diphtheria, but not pertussis. A Td booster should be given every 10 years. Tdap may be given as one of these boosters if you have never gotten Tdap before. Tdap may also be given after a severe cut or burn to prevent

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5 people in 100)

- Swelling of the entire arm where the shot was given (up to about 1 in 500).

Severe problems following Tdap

(Unable to perform usual activities; required medical attention)

- Swelling, severe pain, bleeding and redness in the arm where the shot was given (rare).

Problems that could happen after any vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at fewer than 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your doctor. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**

Vaccine Information Statement

Tdap Vaccine

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Office Use Only

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