

Seasonal Influenza and Pneumococcal Immunization Data Entry Form for MIMS



Facility/Clinic/Agency Name: _____ Provider Code: _____ Name of MIMS Input Clerk: _____
 Location of Clinic: _____ Regional Health Authority: _____ Signature: _____
 Contact Person: _____ Phone: _____ Contact Info: _____

Date of Immunization (YYYY/MM/DD)	Last Name (please print)	Given Name (please print)	PHIN (9 digits)	Date of Birth (YYYY/MM/DD)	Reason for Flu Immunization (Check One)				Vaccine(s) Given	
					Health Care Worker	High Risk	Contact of High Risk	No Risk	Seasonal Flu Tariff Code 8791	Pneu-P-23 Tariff Code 8961
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please submit completed forms to your local public health office as soon as possible.

All Winnipeg only forms should be mailed to: Winnipeg Regional Health Authority
 490 Hargrave Avenue
 Winnipeg, MB, R3A 0X2
 Attn: Influenza Immunization Clerk