PROVIDER MOBILE COVID-19 VACCINATION REQUEST FORM

Santa Clara County PUBLIC HEALTH

HEALTHCARE PROVIDER: Please use this form for patients who require either a first or second dose but cannot go to a vaccination site, due to mobility/medical conditions, including:

(1) patients who received their first dose of COVID-19 vaccine while hospitalized

(2) SNF or LTCF residents

(3) homebound patients who meet Medicare criteria for homebound status

The Public Health Mobile Vaccination Unit will coordinate with the facility or homebound patient to provide the appropriate dose. Please note we only can provide this service to patients residing in Santa Clara County.

PLEASE COMPLETE ALL FIELDS

PATIENT INFORMATION	
Date of Request (MM/DD/YYYY):	
Patient Last Name:	
Patient First Name:	
Patient Date of Birth (MM/DD/YYYY):	
Patient Preferred Language:	

FACILITY/PROVIDER INFORMATION	
Discharging Facility or Referring Provider:	
Facility/Practice Address:	
Facility/Practice Phone Number:	

DISCHARGE INFORMATION

*If patient is being discharged to a **facility**, provide details below:*

Destination Facility Name and Unit:	
Destination Facility Contact:	
Destination Facility Phone Number:	

*If patient is being discharged to **home**, please provide details below:*

If homebound, list patient street address:	
If homebound, list patient phone number:	
If homebound, list patient email address:	

VACCINATION INFORMATION	
Has the patient received a COVID-19 vaccine previously?	YES ☐ NO ☐
If yes, date of first dose (MM/DD/YYYY):	
Vaccine Manufacturer:	
Vaccine Lot Number:	
Adverse Reaction (PLEASE SPECIFY):	
Date Second Dose Is Due (MM/DD/YYYY):	

ELIGIBILITY FOR HOMEBOUND VACCINATON	
Does the patient receive home health services under Medicare?	YES ☐ NO ☐
Does the patient require assistance of another person or medical device (e.g., walker, wheelchair) to leave home? - OR - Does the patient have a condition such that leaving home is contraindicated?	YES ☐ NO ☐
Does leaving home require a considerable and taxing effort?	YES ☐ NO ☐
Please list medical condition(s) contributing to homebound status.	
If there are any other vaccine eligible residents in the household, please list:	

REQUESTOR INFORMATION	
Name of person completing this form:	
Email:	
Phone Number:	

Please note that completion of this form does not eliminate or replace any other reporting requirements to County, State or Federal entities. You should also directly communicate discharge plans with the receiving facility.

Please email completed form to CovidVaxPrepare@PHD.SCCGOV.ORG.