Underinsured Patient VFC Vaccine Referral

Patient Name: ______________________________ ______________________________
First Last

Date of Birth: ______/________/________

This underinsured patient is due for the following vaccinations and is eligible to receive VFC vaccine only from an authorized public health provider or deputized private VFC provider:

Vaccine: ____ Dose #:_________

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Check one of the following:

☐ A copy of this patient's immunization record is attached

☐ I attest that the immunization record for this patient in Nevada WebIZ is accurate and current

Referring Clinic:____

Phone:____

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