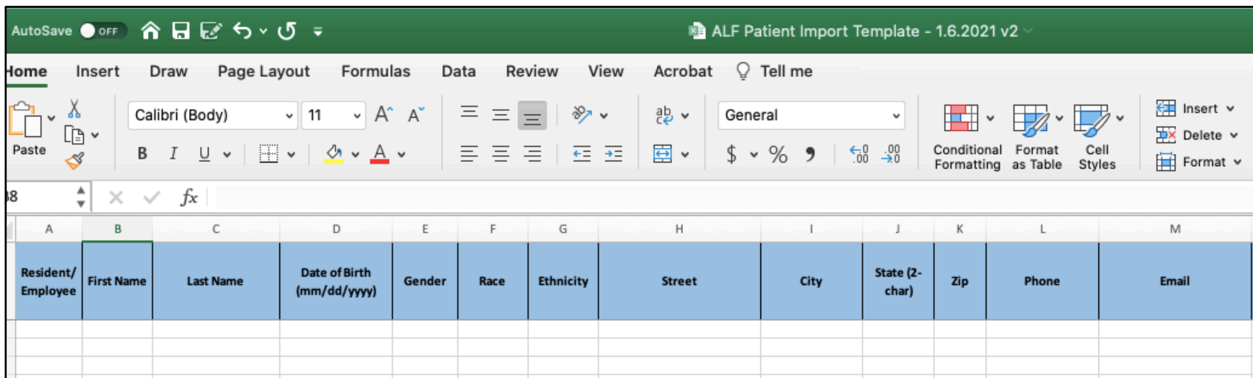
CDR|MAGUIRE
HEALTH & MEDICAL

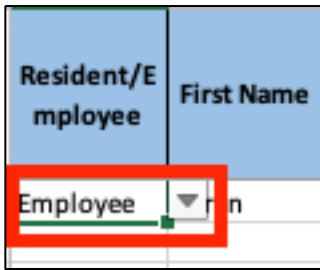
WELCOME TO THE LONG TERM CARE (LTC) FACILITY COVID-19 VACCINATION REGISTRATION RESIDENTS & EMPLOYEES

Step 1: Open the Excel spreadsheet **“LTC Resident and Staff Import Template”**

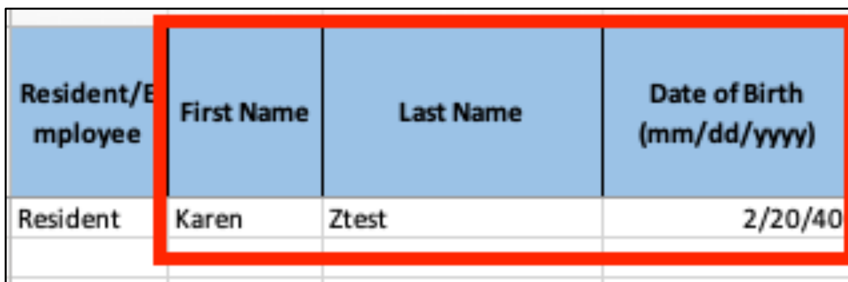
a. Complete the form



Step 2: Using the drop down ▿☐ select **Employee**



Step 3: Enter the Resident’s **First Name, Last Name and Date of Birth**



Step 4: Using the drop down select:

Gender

Resident/Employee	First Name	Last Name	Date of Birth (mm/dd/yyyy)	Gender
Resident	Karen	Ztest	2/20/40	

Male
Female
Other

Race

Resident/Employee	First Name	Last Name	Date of Birth (mm/dd/yyyy)	Gender	Race	Ethnicity	Street
Resident	Karen	Ztest	2/20/40	Female			

White
Black
American Indian/Alaskan Native
Asian/Pacific Islander
Other
Unknown

Ethnicity

Resident/Employee	First Name	Last Name	Date of Birth (mm/dd/yyyy)	Gender	Race	Ethnicity
Resident	Karen	Ztest	2/20/40	Female	White	

Hispanic
Non-Hispanic
Haitian
Unknown

Step 5: Address: Enter employee's personal address in these fields

a. For Residents, enter the LTC Facility address and phone number

Street	City	State (2-char)	Zip	Phone
14244 sw 156 st	Miami	FL	33444	305-334-0769

Step 6: Enter the **Phone and Email Address**

Phone	Email
05-334-0769	karenztest@gmil.com

Step 7: Using the drop down select:

Primary Billing Insurance:

a. If the resident does not have insurance, select **No Insurance Available** and leave the other insurance fields blank

Primary Billing Insurance	Primary Insurance Carrier

Medicare
Medicaid
Insurance
No Insurance Available

Primary Insurance Carrier

a. Scroll to select the Resident's primary insurance carrier

Primary Insurance Carrier	Other Primary Insurance Carrier	P

AARP MEDICARECOMPLETE (AARPMCCOMP-MCR)
AARP (UHC) (AARP-MCR)
ABSOLUTE TOTAL CARE (ABSOLUTE)
ACCESS HEALTH COLORADO (COACCESS)
ACCESS MEDICARE (ACCESSMEDICARE)
ACCESSHEALTH TRI-COUNTY NETWORK (AHTCN)
ACCLAIM INC (ACCLAIM)
ACCOUNTABLE HEALTHCARE IPA (ACCOUNTIPA)
ACS (ACS)
ACTIVA BENEFIT SERVICE (ACTIVA)
ADMINISTRATIVE CONCEPTS (ADMINCONCEPTS)
ADVANTAGE PREFERRED PLUS (ADVPREFPL)

Other Primary Insurance Carrier

a. If available, enter the name of another insurance, if not leave this field blank.

Primary Insurance Carrier	Other Primary Insurance Carrier
AETNA (AETNA)	

Step 8: Enter the **Policy ID No., Group No.,** and the **Insurance Guarantor**

Policy ID No.	Group No.	Insurance Guarantor
123456	60678954	Self

Step 9: Using the drop down select:

Who gave consent for this patient to receive COVID-19 vaccine?

Who gave consent for this patient to receive COVID-19 vaccine?	Do yo h reactions

Self
Caregiver
Other Authorized

Do you have a history of severe allergic reactions (i.e. anaphylaxis) to the COVID-19 Vaccine?

Do you have a history of severe allergic reactions (i.e. anaphylaxis) to other vaccines or other injectable medication (not including the COVID-19 vaccine)?

Do you moderate or acute illness?

Are you allergic to iodine?

Are you allergic to eggs?

Are you allergic to peanuts or nut products?

Are you pregnant or plan to become pregnant?

Are you breastfeeding?

Do you have a bleeding disorder or on a blood thinner?

Do you have a bleeding disorder or on a blood thinner?	Are y on a
Yes / No	

Are you immunocompromised or on a medicine that affects the immune system?

Are you immunocompromised or on a medicine that affects the immune system?	Do for e
Yes / No	

Do you carry an Epi-pen for emergency treatment of anaphylaxis?

Do you carry an Epi-pen for emergency treatment of anaphylaxis?	H vacc
Yes / No	

Have you had any other vaccinations in the previous 14 days?

Have you received a previous dose of any COVID-19 vaccine? If yes, which vaccine?

Step 10: Resident Registration is Complete