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Bethesda Care Norwood
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**Occupational
 Medicine
 Services**

Bethesda Care Queensgate
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Bethesda Care Sharonville
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Good Samaritan
 Phone: 513-862-2875
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CONSENT FOR TWINRIX VACCINATION

I have received and read the _____(date) VIS information concerning the Twinrix vaccine which is used for vaccination against Hepatitis A and Hepatitis B. I have had an opportunity to ask my questions concerning this vaccine and they have been answered to my satisfaction. I understand the benefits and risks of the Twinrix vaccination.

I request that the vaccine be administered to me. I understand that I must receive a series of three doses in order to achieve effectiveness. A blood test is recommended a minimum of four (4) weeks after the last dose to determine immunity against Hepatitis B.

I agree to comply to the following schedule:

- ◆ Initial vaccination
- ◆ The second dose one month after the initial dose
- ◆ The third dose six months after the initial dose

It is my responsibility to come to the TriHealth Occupational Health Center at the recommended times for vaccines and follow-up blood test. As with all medical treatment, there is no guarantee that I will become immune or that I will not experience any adverse side effects from the vaccine.

TWINRIX CONSENT	
Name: _____ <div style="text-align: right;">Print</div>	Company: _____ <div style="text-align: right;">Print</div>
Signature: _____	Date: _____
<i>Witness:</i> _____	<i>Date:</i> _____

VACCINATION ADMINISTERED						
DOSES	DATE	MANUFACTURER/ LOT#	EXP. DATE	SITE	TEMP	GIVEN BY
1 st				1 ml IM ___ delt		
2 nd				1 ml IM ___ delt		
3 rd				1 ml IM ___ delt		
TITRE		RESULTS:				

Adverse reaction after 15 minute wait: Yes____ No_____

Physician Signature: _____