

## **MEDICAL VERIFICATION FORM FOR COVID-19 VACCINE**

Patient Information		
Name		<del></del>
(Last)	(First)	(M.I.)
Date of Birth/		
Primary Phone Number:	Other Phone Number:	·
Email:		Patient does not have access to email
Health Care Provider Information		
The above named patient has two or more medical conditions that I believe puts the patient at significantly increased risk for severe COVID-19 infection or death.		
Healthcare Provider Name:	NPI or Licens	e #:
Provider Facility/Practice Name		
Phone Number:	City/Town	State

Fax to: (603) 271-3001 or Email to: <a href="mailto:covidvaccinescheduling@dhhs.nh.gov">covidvaccinescheduling@dhhs.nh.gov</a>

## <u>List of Underlying Medical Conditions (adapted from CDC):</u>

Phase 1b: Two or more conditions

- Cancer
- Chronic Kidney Disease
- COPD (Chronic Obstructive Pulmonary Disease)
- Down Syndrome
- Heart Conditions, such as heart failure, coronary artery disease, or cardiomyopathies
- Immunocompromised state (weakened immune system) from solid organ transplant
- Obesity (body mass index of 30 kg/m or higher but < 40 kg/m</li>
- Severe Obesity (body > 40 kg/m)
- Pregnancy
- Sickle cell disease
- Other High Risk Pulmonary Disease
- Type 2 Diabetes Mellitus

Note: Flexibility is provided for a health care provider to vaccinate any patient whose primary care provider assesses a significant risk for severe illness due to any multiple co-occurring co-morbidities.