COVID-19 Vaccination Service – Record form

**Version 21**

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| Patient’s details | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Surname\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Address\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Postcode\* |  |  |  |  |  |  |  |  |  | | | | | | | | | | | | | | | | | | |
| Date of birth\* |  |  | / |  |  |  | / |  |  |  | |  | DD/MMM/YYYY – 01/JAN/2000 | | | | | | | | | | | | | | |
| Sex\* | ⧠ Male ⧠ Female ⧠ Not Stated | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NHS No. |  |  |  |  |  |  |  |  |  | |  |  |  |  | | | | | | | | | | | | | |
| GP Practice\*  Address\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Clinical Screening | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Eligibility Type | 1. Individual lives in a Care Home? 2. Individual works in a Care Home? 3. Individual is a health care worker? 4. Individual is a social care worker? 5. Individual is eligible due to their age? 6. Individual is eligible due to pregnancy? 7. Individual is immunosuppressed. 8. Individual is clinically at risk? 9. Individual is either homeless or lives in a closed setting such as residents of supported living accommodation? 10. Individual is a household contact of people with immunosuppression? 11. Individual is a carer? 12. Individual has had CAR-T therapy or stem cell transplantation since receiving their last vaccination? | | | | | | | | | | | | | | | | | ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes | | | | | ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No | | | | | |
| Staff Organisation |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  | |  |  |  |  |  |
| Staff Role |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  | |  |  |  |  |  |
| Employee Number |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  | |  |  |  |  |  |
| Exclusion Checklist\* | Does the individual have a history of Anaphylaxis or significant allergic reactions to any vaccines or it’s ingredients?  Has the individual experienced any serious adverse reaction after previous COVID-19 vaccine doses?  Has the individual indicated that they are, or could be pregnant? | | | | | | | | | | | | | | | | | ⧠ Yes  ⧠ Yes  ⧠ Yes | | | | | ⧠ No  ⧠ No  ⧠ No | | | | | |
| Caution Checklist\* | 1. Is the individual taking anticoagulant medication, or do they have a bleeding disorder? | | | | | | | | | | | | | | | | | ⧠ Yes | | | | | ⧠ No | | | | | |

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| Consent | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Consent\* | Do you give consent to receive the vaccine? | | | | | | | | | | | | | | | | | | | | | ⧠ Yes | | | | ⧠ No | | |
| Consent provided by\* | ⧠ Patient  ⧠ Consent Given by Person with Parental Responsibility  ⧠ Healthcare Lasting Power of Attorney  ⧠ Court Appointed Deputy  ⧠ Clinician using Best Interests process of Mental Capacity Act  ⧠ Consent given by Independent Mental Capacity Advocate | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If consent was **not** obtained by the Patient, then please complete the below fields: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Individual Consulted |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  |
| Authorising Clinician |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  |
| Registration Number |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  |
| Notes |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Outcome | |
| Outcome\* | ⧠ Continue with vaccine administration  Vaccination not given (see ‘Vaccine not given’ section on Page 3) |
| Planned Vaccine Type | ⧠ Comirnaty Original/Omicron BA.4-5 15micrograms/15micrograms/0.3ml (Pfizer) ⧠ Comirnaty Omicron XBB.1.5 6 months - 4 years 3micrograms/0.2ml (Pfizer)  ⧠ Comirnaty Omicron XBB.1.5 Children 5-11 years 10micrograms/0.3ml (Pfizer) ⧠ Comirnaty Omicron XBB.1.5 30micrograms/0.3ml (Pfizer)  ⧠ Spikevax XBB.1.5 0.1mg/1ml (Moderna) |
| Dose Sequence\* | ⧠ First Dose  ⧠ Second Dose  ⧠ Booster |

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| Pre-screening Clinician | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Surname\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Professional body registration no.\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature\* |  | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Vaccination details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of vaccination\* |  |  | / | |  | |  | |  | | / | |  | |  |  | |  | | DD/MMM/YYYY – 01/JAN/2000 | | | | | | | | | | | | | | | |
| Time of vaccination\* |  |  | : | |  | |  | | HH:MM – 17:56 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dose Sequence\* | ⧠ First Dose  ⧠ Second Dose  ⧠ Booster | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Vaccine\* | ⧠ Comirnaty Original/Omicron BA.4-5 15micrograms/15micrograms/0.3ml (Pfizer) ⧠ Comirnaty Omicron XBB.1.5 6 months - 4 years 3micrograms/0.2ml (Pfizer)  ⧠ Comirnaty Omicron XBB.1.5 Children 5-11 years 10micrograms/0.3ml (Pfizer) ⧠ Comirnaty Omicron XBB.1.5 30micrograms/0.3ml (Pfizer)  ⧠ Spikevax XBB.1.5 0.1mg/1ml (Moderna) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Batch Number\* |  |  | |  | |  | |  | |  | |  | |  |  | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |
| Manufacturer’s expiry date\* |  |  | | / | |  | |  | |  | | / | |  |  | |  | |  | | DD/MMM/YYYY – 01/JAN/2000 | | | | | | | | | | | | | | |
| Use by date\* |  |  | | / | |  | |  | |  | | / | |  |  | |  | |  | | DD/MMM/YYYY – 01/JAN/2000 | | | | | | | | | | | | | | |
| Administration Site\* | ⧠ Left deltoid  ⧠ Right deltoid  ⧠ Left thigh  ⧠ Right thigh | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dose Amount | ⧠ 0.5ml  ⧠ 0.1ml  ⧠ 0.3ml  ⧠ 0.2ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Route of administration\* | ⧠ Intramuscular | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Any adverse effects\* | ⧠ None Observed  ⧠ Yes (please note details in notes section below) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Vaccine not given | |
| Dose sequence not given | ⧠ First Administration  ⧠ Second Administration  ⧠ Booster |
| Reason vaccine not administered | ⧠ Generally feeling unwell / Symptomatic  ⧠ Contraindications / Clinically not suitable  ⧠ Consent not given |

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| Notes | |
| Clinical notes  e.g., adverse reactions |  |

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| Vaccination Location | | | | | | | | | | | | | | | | | | | | | | | | | |
| Care Model | ⧠ Hospital Hub  ⧠ Vaccination Centre  ⧠ Care Home  ⧠ Home Of Housebound Patient  ⧠ Off-site Outreach Event | | | | | | | | | | | | | | | | | | | | | | | | |
| Care Home Details |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Vaccinator | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Surname\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Professional body registration no.\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature\* |  | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Vaccine Drawer | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Surname\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Responsible Drawer First Name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Responsible Drawer Surname |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Professional body registration no.\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature\* |  | | | | | | | | | | | | | | | | | | | | | | | | | |

If drawer is not registered with a professional body, capture Responsible drawer name and registration no

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| Responsible Clinician | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Surname\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Professional body registration no.\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature\* |  | | | | | | | | | | | | | | | | | | | | | | | | | |