Flu Vaccination Service – Record form V2

Please fill form in **BLOCK** capitals

\* indicates section is mandatory and must be completed

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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 | | | | | | | | | | | | | | |
| Gender\* | ⧠ Male ⧠ Female ⧠ Not Stated | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NHS No. |  |  |  |  |  |  |  |  |  | |  |  |  |  | | | | | | | | | | | | | |
| GP Practice\*  Address\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Consent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Consent\* | Do you give consent to receive the vaccine? | | | | | | | | | | | | | | | | | | | | | | ⧠ Yes | | | | ⧠ No | | |
| Consent provided by\* | ⧠ Informed consent given for treatment  ⧠ Consent given by person with parental responsibility  ⧠ Consent given by Court Appointed Deputy  ⧠ Consent given by Independent Mental Capacity Advocate  ⧠ Clinician decision to vaccinate following the Best Interests process of the Mental Capacity Act  ⧠ Consent given by person with lasting power of attorney for personal welfare | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If consent was **not** obtained by the Patient, then please complete the below fields: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Individual Consulted |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | |  |  |  | |  |  |
| Authorising Clinician |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | |  |  |  | |  |  |
| Registration Number |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | |  |  |  | |  |  |
| Pregnant?\* | Is the individual having a vaccine today because they are pregnant? | | | | | | | | | | | | | | | | | | | | | ⧠ Yes | | | | | ⧠ No | | |
| Notes |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Outcome | | | |
| Outcome\* | ⧠ Continue with vaccine administration  ⧠ Vaccination not given (see ‘Vaccine not given’ section on Page 3) | | |
| Additional Information | | | |
| Occupation\* | 1. Are you a carer? 2. Are you a social care worker? 3. Are you a health care worker? 4. Do you work in a residential care home for older people? 5. Do you live in a residential care home?   ⧠ Not Stated | ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes | ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No |

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| Vaccination details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of vaccination\* |  |  | / | |  | |  | |  | | / | |  | |  |  | |  | | DD/MMM/YYYY – 01/JAN/2000 | | | | | | | | | | | | | | |
| Time of vaccination\* |  |  | : | |  | |  | | HH:MM – 17:56 | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Vaccine\* | ⧠ Fluenz Tetra – LAIV (AstraZeneca)  ⧠ Quadrivalent Influvac sub – Unit Tetra – QIVe – Viatris  ⧠ Quadrivalent Influenza Vaccine – QIVe – Sanofi Pasteur  ⧠ Supemtek – QIVr – Sanofi Pasteur  ⧠ Flucelvax Tetra – QIVc – Seqirus  ⧠ Fluad Tetra – aQIV – Seqirus  ⧠ Cell-based Quadrinalent – QIVc- Seqirus  ⧠ Adjuvanted Quadrivalent – aQIV- Seqirus | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Batch Number\* |  |  | |  | |  | |  | |  | |  | |  |  | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Manufacturer’s expiry date\* |  |  | | / | |  | |  | |  | | / | |  |  | |  | |  | | DD/MMM/YYYY – 01/JAN/2000 | | | | | | | | | | | | | |
| Administration Site\* | ⧠ Left Buttock  ⧠ Left Thigh  ⧠ Left Upper Arm  ⧠ Nasal  ⧠ Right Buttock  ⧠ Right Thigh  ⧠ Right Upper Arm | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Any adverse effects\* | ⧠ None Observed  ⧠ Yes (please note details in notes section below) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Vaccine not given | |
| Reason vaccine not administered | ⧠ Generally feeling unwell / Symptomatic  ⧠ Contraindications / Clinically not suitable  ⧠ Consent not given / Refused |

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

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| Vaccination Location | |
| Location Type | ⧠ Onsite at a Hospital Hub  ⧠ Onsite at a PCN LVS  ⧠ Onsite at a Pharmacy run LVS  ⧠ Onsite at a Vaccination Centre  ⧠ Roving at a detained setting  ⧠ Roving at a Long-term Residential Care Facility  ⧠ Roving at a domiciliary care visit to someone’s private residence  ⧠ Not Recorded |

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

If drawer is not registered with a professional body, please capture Responsible drawer name and registration

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| For Care Home use only | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CQC Number |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Care Home Name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Care Home Post Code |  |  |  |  |  |  |  |  |  | | | | | | | | | | | | | | | | | |