Flu Vaccination Service – Record form V2

Please fill form in **BLOCK** capitals

\* indicates section is mandatory and must be completed

|  |
| --- |
| Patient’s details |
| First name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Surname\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Address\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Postcode\* |  |  |  |  |  |  |  |  |  |
| Date of birth\* |  |  | / |  |  |  | / |  |  |  |  | DD/MMM/YYYY – 01/JAN/2000 |
| Gender\* | ⧠ Male ⧠ Female ⧠ Not Stated |
| NHS No. |   |  |  |  |  |  |  |  |  |  |  |  |  |
| GP Practice\*Address\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| 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 |  |

|  |
| --- |
| 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 |

|  |
| --- |
| 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) |

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

|  |
| --- |
| Notes |
| Clinical notese.g. adverse reactions  |  |

|  |
| --- |
| 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 |

|  |
| --- |
| 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

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