COVID-19 Vaccination Service – Record form

**Version 13**

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

|  |
| --- |
| 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\* | 1. Is the individual currently unwell with fever or having any symptoms of COVID-19 infection?
2. Has the individual been vaccinated against shingles in the last 7 days?
3. Does the individual have a history of any of the following?
	* Anaphylaxis
	* Reaction to a previous dose of COVID-19 Vaccine?
	* Significant unexplained allergies
4. Has the individual informed you they are currently or have been in a trial of a potential coronavirus vaccine?
5. Has the individual been previously diagnosed with COIVD-19 vaccine related myocarditis or pericarditis?
6. Does the individual have a history of capillary leak syndrome?
7. Does the individual have a history of Idiopathic Thrombocytopenia (ITP)?
8. Has the individual indicated they are, or could be pregnant?
 | ⧠ Yes⧠ Yes⧠ Yes⧠ Yes⧠ Yes⧠ Yes⧠ Yes⧠ Yes | ⧠ No⧠ No⧠ No⧠ No⧠ No⧠ No⧠ No⧠ No |
| Caution Checklist\* | 1. Is the individual taking anticoagulant medication, or do they have a bleeding disorder?
 | ⧠ Yes | ⧠ No |

|  |
| --- |
| 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 |  |

|  |
| --- |
| Outcome |
| Outcome\* | ⧠ Continue with vaccine administration⧠ Vaccination not given (see ‘Vaccine not given’ section on Page 3) |
| Planned Vaccine Type | ⧠ Comirnaty 30micrograms/0.3mldose (Pfizer)⧠ Comirnaty Children 5-11 years 10 micrograms/ 0.2ml dose (Pfizer)⧠ Comirnaty Original/Omicron 15 micrograms/0.3ml dose (Pfizer)⧠ Nuvaxovid 5micrograms/0.5ml dose (Novavax)⧠ Spikevax 0.1mg/0.5ml dose (Moderna)⧠ Spikevax Omicron 0.1mg/0.5ml dose (Moderna)⧠ Vaxzevria 0.5ml dose (AstraZeneca) |
| Dose Sequence\* | ⧠ First Dose⧠ Second Dose⧠ Booster |

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

|  |
| --- |
|  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\* | ⧠ COVID-19 mRNA Vaccine BNT162b2 30micrograms/0.3ml dose concentrate for suspension for injection multidose vials (Pfizer-BioNTech)⧠ COVID-19 Vaccine AstraZeneca (ChAdOx1 S [recombinant]) 5x10,000,000,000 viral particles/0.5ml dose solution for injection multidose vials⧠ 8 dose vial⧠ 10 dose vial⧠ COVID-19 mRNA (nucleoside modified) Vaccine Moderna 0.1mg/0.5mL dose dispersion for injection multidose vials⧠COVID-19 Vaccine Comirnaty Children 5-11 years 10 micrograms/0.2ml (Pfizer) |
| 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) |

|  |
| --- |
| 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 |

|  |
| --- |
| 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\* |  |

|  |
| --- |
|  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

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

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