Flu Vaccination Service – Record form

**Version 3**

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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 a household contact of people with immunosuppression? 10. Individual is a carer? 11. 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 | | | | | | | ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No | | | | | | | |
| Consent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Consent\* | | | Do you give consent to receive the vaccine? | | | | | | | | | | | | | | | | | | | | | | | ⧠ Yes | | | | | | ⧠ No | | |
| Consent type\* | | | ⧠ 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 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 | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | |  |  |  |  | | | |  |  |  | |  |  |
| Notes | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pregnancy | | Is the individual having a vaccine today because they are pregnant? | | | | | | | | | | | | | | | | | | | ⧠ Yes | | | | | | | ⧠ No | | | | | | |

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| Outcome | |
| Outcome\* | ⧠ Continue with vaccine administration  ⧠ Vaccination not given (see ‘Vaccine not given’ section on Page 2) |

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

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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\* | ⧠ AstraZeneca – Fluenz Tetra - LAIV  ⧠ Sanofi Pasteur  ⧠ Quadrivalent Influenza Vaccine - QIVe  ⧠ Supemtek - QIVr  ⧠ Seqirus  ⧠ Flucelvax Tetra - QIVc  ⧠ Fluad Tetra – aQIV  ⧠ Viatris – Quadrivalent Influvac Sub – unit Tetra - QIVe | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Batch Number\* |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Manufacturer’s expiry date\* |  |  | |  | |  | |  | |  | |  | |  |  | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Use by date\* |  |  | | / | |  | |  | |  | | / | |  |  | |  | |  | | DD/MMM/YYYY – 01/JAN/2000 | | | | | | | | | | | | | |
| Administration Site\* | ⧠ Left buttock  ⧠ Left thigh  ⧠ Left upper arm  ⧠ Nasal  ⧠ Right buttock  ⧠ Right thigh  ⧠ Right upper arm | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Vaccination Location | |
| Location Type | ⧠ Hospital Hub  ⧠ Vaccination Centre  ⧠ Home of Housebound Patient  ⧠ Off-site Outreach Event |
| Vaccinator Organisation |  |
| Vaccination Site |  |

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

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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\* |  | | | | | | | | | | | | | | | | | | | | | | | | | |