COVID-19 Vaccination Service – Record form

**Version 7.0**

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 | | | | | | | | | | | | | | |
| Sex\* | ⧠ Male ⧠ Female ⧠ Not Stated | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NHS No. |  |  |  |  |  |  |  |  |  | |  |  |  |  | | | | | | | | | | | | | |
| GP Practice\*  Address\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Clinical Screening | | | |
| Exclusion Checklist\* | 1. Has the individual experienced major venous and/or arterial thrombosis occurring with thrombocytopenia following vaccination with any COVID-19 vaccine 2. Has the individual had any vaccination in the last 7 days? 3. Is the individual currently unwell with fever? 4. Has the individual ever had any serious allergic reaction to any ingredients of the Covid-19 vaccines, drug or other vaccine? 5. Has the individual ever had an unexplained anaphylaxis reaction? 6. Does the individual have a history of heparin-induced thrombocytopenia and thrombosis (HITT or HIT type 2)? | ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes | ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No |
| Caution Checklist\* | 1. Has the individual indicated they are, or could be pregnant? 2. Has the individual informed you they are currently or have been in a trial of a potential coronavirus vaccine? 3. Is the individual taking anticoagulant medication, or do they have a bleeding disorder? 4. Does the individual currently have any symptoms of Covid -19 infection? | ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes | ⧠ No  ⧠ No  ⧠ No  ⧠ No |
| Second dose only question | 1. Has the individual experienced an urticarial (itchy) skin reaction following their first COVID-19 vaccine dose? | ⧠ Yes | ⧠ No |

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| Consent | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Consent\* | Do you give consent to receive the vaccine? | | | | | | | | | | | | | | | | | | | | | ⧠ Yes | | | | ⧠ No | | |
| Consent provided by\* | ⧠ Patient  ⧠ Healthcare Lasting Power of Attorney  ⧠ Court Appointed Deputy  ⧠ Clinician using Best Interests process of Mental Capacity Act | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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) | | |
| 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 |
| Ethnic Category | What is your ethnic category?  White  ⧠ British  ⧠ Irish  ⧠ Other White  Mixed  ⧠ White and Black Caribbean  ⧠ White and Black African  ⧠ White and Asian  ⧠ Other Mixed  Asian or Asian British  ⧠ Indian  ⧠ Pakistani  ⧠ Bangladeshi  ⧠ Other Asian  Black or Black British  ⧠ Caribbean  ⧠ African  ⧠ Other Black  Other Ethnic Groups  ⧠ Chinese  ⧠ Other  ⧠ Not Stated | | |

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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 Administration  ⧠ Second Administration | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 |
| 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 | |
| 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\* |  | | | | | | | | | | | | | | | | | | | | | | | | | |

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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, 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 |  |  |  |  |  |  |  |  |  | | | | | | | | | | | | | | | | | |