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 WhiteMixed⧠ White and Black Caribbean⧠ White and Black African⧠ White and Asian⧠ Other MixedAsian or Asian British⧠ Indian⧠ Pakistani⧠ Bangladeshi⧠ Other AsianBlack or Black British⧠ Caribbean⧠ African⧠ Other BlackOther 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 notese.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 |  |  |  |  |  |  |  |  |  |