|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Details:**   |  |  |  |  | | --- | --- | --- | --- | | **First Name** |  | **Surname** |  | | **Date of birth** |  | **Ethnicity** |  | | **Gender (circle as appropriate)** | Male Female Prefer not to say | | | | **Home address**  **Post Code** |  | | | |  | **Ward** |  | | **NHS number** |  | **Hospital Number** |  | | **GP name and address** |  | | | |
| **Assessment for Consent:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Screening questions** | **Column 1** | |  | **Column 2** | | **Date of 1st primary vaccination: ……………………………………………………….. Make/Brand …………………………………………………………………………………………..** | | | | | | **Date of 2nd primary vaccination: ……………………………………………………….. Make/Brand …………………………………………………………………………………………..** | | | | | | **Date of 3rd vaccination: ……………………………………………………………………..Make/Brand…………………………………………………………………………………………….** | | | | | | **Date of 4th vaccination (if applicable):……….………………………………………..Make/Brand…………………………………………………………………………………………….** | | | | | | **Date of 5th vaccination (if applicable)…………………………………………………… Make/Brand…………………………………………………………………………………………..** | | | | | | **Is the patient currently unwell with high temperature or do you currently have any symptoms of Covid19? If Yes delay vaccine** | **No** |  | **Yes** |  | | **Have they had an allergic reaction to a previous Covid19 vaccine which required medical treatment? If Yes discuss with Dr Mike Tarzi (Consultant Immunologist) via switchboard** | **No** |  | **Yes** |  | | **Do they have any allergies to a medicine or an unknown substance that has resulted in a significant allergic reaction e.g. immediate rash, urticaria (hives), anaphylaxis, swelling of lips or tongue, difficulty breathing and/or requires you to carry an adrenaline auto-injector?** | **No** |  | **Yes\*** |  | | **Are they pregnant or planning to become pregnant or breastfeeding?** | **No** |  | **Yes\*** |  | | **Have the been previously diagnosed with COVID-19 vaccine-related myocarditis or pericarditis?** | **No** |  | **Yes\*** |  | | **Are they on anticoagulants (blood thinning medicines) or have a bleeding disorder?** | **No** |  | **Yes\*** |  | | **Is their BMI ≥ 40?** | **No** |  | **Yes\*** |  | | **Are they taking part in a Covid trial?** | **No** |  | **Yes\*** |  | | **Have they been diagnosed with Covid-19 in the last 4 weeks?** | **No** |  | **Yes\*** |  | |
| **\*If Yes discuss with senior ward dr, document decision and proceed if appropriate.**  **Consent:** The COVID vaccine will reduce the chance of you suffering from COVID 19 disease. Like all medicines no vaccine is completely effective and it takes a few weeks for your body to build up protection from the vaccine. Some people may still get COVID 19 despite having a vaccination, but this should lessen the severity of any infection.  **Consent to the vaccination given by patient or next of kin:**  **Signed: Date:** |
| **For Official Use Only (Screener/Prescriber Use)**  **Clinical Review Notes**   |  |  | | --- | --- | | ***Decision to proceed to:*** | ***Brand of vaccine:*** | | Vaccine  MDT review | Spikevax (Moderna) COVID-19 Vaccine 0.5mL intra-muscularly  Comirnaty (Pfizer/BNT) COVID-19 Vaccine 0.3mL intra-muscularly | |
| **Prescribing Particulars (Prescriber use only)**  **Individual Patient Specific Direction (PSD):-**  In accordance with Public Health England Immunisation against infectious disease (Green Guide) and JCVI recommendations for the purpose of protection against COVID-19.     |  |  |  |  | | --- | --- | --- | --- | | **Name of Prescriber** | **Signature of Prescriber** | **Registration Number** | **Date** | |  |  |  |  | |
|  |
| **Record of administration of COVID-19 vaccine**   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Date of Booster**  **vaccination** | **Site of injection** | | **Batch number** | **Expiry date** | **Brand of vaccine** | **Immuniser name** | **Immuniser signature** | | **…………** | **L arm** | **R arm** |  |  |  |  |  | |
| |  |  | | --- | --- | | **Vaccination Hub** | | | RSCH |  | | PRH |  | | WRH |  | | SRH |  |   **Please prescribe on EPMA system in order for Nurse to administer.** |