|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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.** |