|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** |  | | | | | **Already Received Flu Vaccine elsewhere: Location (If known) …………………………………………………………… Date:………………………………………………..** | | | | | | Are they over the age of 65? (If “Yes” choice: Seqirus AQIV or QIVc where available) | **No** |  | **Yes** |  | | Are they aged from 18yrs to less than 65 years of age in a clinical risk group category listed in [Chapter 19](https://www.gov.uk/government/publications/influenza-the-green-book-chapter-19) of the Green Book such as those with:   * + chronic (long-term) respiratory disease, such as asthma (that requires continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission), chronic obstructive pulmonary disease (COPD) or bronchitis   + chronic heart disease and vascular disease, such as heart failure   + chronic kidney disease at stage 3, 4 or 5   + chronic liver disease   + chronic neurological disease, such as Parkinson’s disease or motor neurone disease   + learning disability   + diabetes and adrenal insufficiency   + asplenia or dysfunction of the spleen   + a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment)   + morbidly obese adults (aged from 16 years) with a BMI of 40kg/m2 and above   (If “Yes” then consider vaccine, if **No,** the ineligible) | **No** |  | **Yes** |  | | Have they ever had a severe reaction to any vaccine? | **No\*** |  | **Yes** |  | | Do they have an allergy to any vaccine component *(e.g. neomycin, formaldehyde, CTAB or polysorbate 80)*? | **No\*** |  | **Yes** |  | | Have they ever had a severe allergic reaction to eggs/ do they suffer from egg allergy and uncontrolled asthma?  (If “**Yes**” choice: Seqirus QIVc) | **No** |  | **Yes** |  | | Have they experienced fever and muscle pains in the last 24 hours? If “**Yes**” delay vaccination until recovery | **No** |  | **Yes** |  | | Do they suffer from a bleeding disorder? | **No\*** |  | **Yes** |  | | Are they taking any blood thinning medication? | **No\*** |  | **Yes** |  | |
| **\*Discuss with senior doctor, document decision and proceed if appropriate.**  **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  Review with Senior Clinician |  | |
| **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 Influenza.  Please prescribe on Electronic Prescribing and Medicines Administration (EPMA) System   |  |  |  |  | | --- | --- | --- | --- | | **Name of Prescriber** | **Signature of Prescriber** | **Registration Number** | **Date** | |  |  |  |  | |
|  |
| **Record of administration of Influenza vaccine**   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Date of**  **vaccination** | **Site of injection** | | **Batch number** | **Expiry date** | **Brand of vaccine** | **Immuniser name** | **Immuniser signature** | | **…………** | **L arm** | **R arm** |  |  |  |  |  | |
| |  |  | | --- | --- | | **Vaccination Location** | | | RSCH |  | | PRH |  | | WRH |  | | SRH |  |   **Please prescribe on EPMA system in order for Nurse to administer.** |