|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** |  |  |  |  |  |

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|

|  |
| --- |
| **Vaccination Location** |
| RSCH | [ ]  |
| PRH | [ ]  |
| WRH | [ ]  |
| SRH | [ ]  |

 **Please prescribe on EPMA system in order for Nurse to administer.** |