## **NHS Flu Vaccination Service – Record Form (Information which must be recorded in the point of care system)** \* indicates sections that must be completed

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| **Patient’s details** |
| First name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Surname\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Address\* |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Postcode |   |  |  |  |  |  |  |  |  |
| Telephone |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Date of birth\* |  |  |  |  |  |  | NHS No. |  |  |  |  |  |  |  |  |  |  |  |  |
| GP practice\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Patient’s emergency contact** |
| Name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Telephone |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Relationship to patient |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Any allergies |  |
| Eligible patient group\* | [ ]  65 years or over | [ ]  Chronic respiratory disease  |
|  | [ ]  Chronic heart disease | [ ]  Chronic kidney disease |
|  | [ ]  Chronic liver disease | [ ]  Chronic neurological disease |
|  | [ ]  Diabetes | [ ]  Immunosuppression |
|  | [ ]  Asplenia / splenic dysfunction | [ ]  Pregnant woman |
|  | [ ]  Person in long-stay residential care home or care facility | [ ]  Carer |
|  | [ ]  Household contact of immunocompromised individual | [ ]  Morbid obesity (BMI ≥ 40) |
|  | [ ]  Workers employed through Direct Payment of Personal Health Budget | [ ]  Learning disability |
|  | [ ]  Frontline Health & Social care worker | [ ]  Hospice worker |

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| **Vaccination details** |
| Name of vaccine/ manufacturer\* | Apply vaccine sticker if available | Date of vaccination\* |  |  |  | Pharmacy stamp |
| Batch Number\* |  | Injection site\* | [ ]  Left upper arm [ ]  Right upper arm |  |
| Expiry Date\* |  | Route of administration\* | [ ]  Intramuscular [ ]  Subcutaneous |
| Location (if not in the pharmacy)\* | [ ]  Patient’s home[ ]  Long-stay care home or long-stay residential facility[ ]  Other location (please state):  |
| Any adverse effects\* |  |
| Advice given and any other notes |  |
| Administered by\* |  | Signature\* |  | Registration number |  |  |  |  |  |  |  |