NHS Community Pharmacy Seasonal Influenza Vaccination Advanced Service - Record & Consent Form

\* indicates sections that must be completed

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Patient’s details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name\* |  | |  |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | | |  | |  | |  | | |  | |  | | |  | |  | | |  | |
| Surname\* |  | |  |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | | |  | |  | |  | | |  | |  | | |  | |  | | |  | |
| Address |  | |  |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | | |  | |  | |  | | |  | |  | | |  | |  | | |  | |
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| Postcode |  | |  |  | |  | |  | |  | |  | |  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Telephone |  | |  |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | | |  | |  | |  | | |  | |  | | |  | |  | | |  | |
| Date of birth\* |  | |  |  | |  | |  | |  | | NHS No. | | | | | |  | |  | |  | |  | | |  | |  | |  | | |  | |  | | |  | |  | | |  | |
| GP practice\* |  | |  |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | | |  | |  | |  | | |  | |  | | |  | |  | | |  | |
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| **Patient’s emergency contact** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | | |  | |  | |  | | |  | |  | | |  | |  | | |  |
| Telephone | | | | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | | |  | |  | |  | | |  | |  | | |  | |  | | |  |
| Relationship to patient | | | | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | | |  | |  | |  | | |  | |  | | |  | |  | | |  |
| **Patient consent** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. I agree to be given a flu vaccination by a trained pharmacist. 2. I confirm I have not already received a flu vaccination for this flu season. 3. I declare that the information I have given on this form is correct and complete. 4. I consent to the disclosure of relevant information, where appropriate, from this form to:  * my GP practice to help them provide care to me; and * NHS England (the national NHS body that manages pharmacy and other health services) and the NHS BSA for the purposes of checking payments to the pharmacy and to allow them to make sure the service is being provided properly. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature | |  | | | | | | | | | | | | | | | | | | | | | | | | Date | | | | | | |  | | | | |  | | | | |  | | |

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| **To be completed by pharmacy staff** | | | | | | | | | | | | | | | | | | |
| 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) | | | | | | | | | | |
| Social care worker | | | | | |  | | | | | | | | | | |
| **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 | | | | |
| Any adverse effects\* |  | | | | | | | | | | | | | | | | | |
| Advice given and any other notes |  | | | | | | | | | | | | | | | | | |
| Administered by\*  (pharmacist name) |  | | Signature\* | |  | | | | GPhC number\* | | |  |  |  |  |  |  |  |

**CONFIDENTIAL**