**NHS Flu Vaccination Service - Record 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 | | | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | | |  | |  | |  | |  | |  | |  | |  | |  | |  |
| 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 | | | | | | | | | | | | | | | | | | | 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 | | | | | | | | | | | | | | | |
| Any adverse effects\* |  | | | | | | | | | | | | | | | |
| Advice given and any other notes |  | | | | | | | | | | | | | | | |
| Administered by\*  (pharmacist name) |  | Signature\* | |  | | | GPhC number\* | | |  |  |  |  |  |  |  |