COVID-19 Vaccination Service – Record form

**Version 13.0**

Please fill form in **BLOCK** capitals

\* indicates section is mandatory and must be completed

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| Patient’s details | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Surname\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Address\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Postcode\* |  |  |  |  |  |  |  |  |  | | | | | | | | | | | | | | | | | | |
| Date of birth\* |  |  | / |  |  |  | / |  |  |  | |  | DD/MMM/YYYY – 01/JAN/2000 | | | | | | | | | | | | | | |
| Sex\* | ⧠ Male ⧠ Female ⧠ Not Stated | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NHS No. |  |  |  |  |  |  |  |  |  | |  |  |  |  | | | | | | | | | | | | | |
| GP Practice\*  Address\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Clinical Screening\* | | |
| 1. Is the individual currently unwell with a fever, or having any symptoms of COVID-19 infection? 2. Is the individual aged 18 or over, and had any COVID-19 symptoms or tested positive for COVID-19 over the last 4 weeks?\*\* 3. Is the individual aged less than 18 years, and had any COVID-19 symptoms or tested positive for COVID-19 over the last 12 weeks? 4. Has the individual been vaccinated against shingles in the last 7 days?”\*\* 5. Does the individual have a history of any of the following?  * Anaphylaxis * Reaction to a previous dose of COVID-19 vaccine * Significant unexplained allergies  1. Has the individual informed you they are currently or have been in a trial of a potential coronavirus vaccine? 2. Has the individual been previously diagnosed with COVID-19 vaccine-related myocarditis or pericarditis? 3. Does the individual have a history of capillary leak syndrome?\*\* 4. Does the individual have a history of Idiopathic Thrombocytopenia (ITP)? 5. Has the individual indicated they are, or could be pregnant?\*\* 6. Is the individual taking anticoagulant medication, or do they have a bleeding disorder? | ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes | ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No |

\*\*not applicable to under 5s

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| Consent | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Consent\* | Do you give consent to receive the vaccine? | | | | | | | | | | | | | | | | | | | | | ⧠ Yes | | | | ⧠ No | | |
| Consent provided by\* | ⧠ Patient  ⧠ Parent/Guardian  ⧠ Healthcare Lasting Power of Attorney  ⧠ Court Appointed Deputy  ⧠ Independent Mental Capacity Advocate (IMCA)  ⧠ Clinician using Best Interests process of Mental Capacity Act | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If consent was **not** obtained by the Patient, then please complete the below fields: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Individual Consulted |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  |
| Authorising Clinician |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  |
| Registration Number |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  |
| Notes (e.g. relationship to patient) |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Outcome | | | |
| Outcome\* | ⧠ Continue with vaccine administration  ⧠ Vaccination not given (see ‘Vaccine not given’ section below) | | |
| Eligibility Criteria | | | |
| Reason for vaccination\* (select one): | 1. Residents in a care home 2. Staff working in care homes 3. Healthcare workers 4. Social care workers 5. Age based eligibility 6. Pregnancy 7. People with immunosuppression 8. People in other clinical risk groups 9. People who are homeless, or people who live in closed settings such as supported living accommodation 10. Household contacts of people with immunosuppression 11. Carers 12. People needing re-vaccination as a result of CAR-T therapy or stem-cell transplants | ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes | ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No |

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| Pre-screening Clinician | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Surname\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Professional body registration no.\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature\* |  | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Vaccination details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of vaccination\* |  |  | / | |  | |  | |  | | / | |  | |  |  | |  | | DD/MMM/YYYY – 01/JAN/2000 | | | | | | | | | | | | | | |
| Time of vaccination\* |  |  | : | |  | |  | | HH:MM – 17:56 | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dose Sequence\* | ⧠ First Administration  ⧠ Second Administration  ⧠ Booster/Maintenance | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Vaccine\* | ⧠ Comirnaty COVID-19 mRNA Vaccine 30micrograms/0.3ml dose concentrate for dispersion for injection multidose vials (Pfizer-BioNTech)  ⧠ Comirnaty Children 5-11 years COVID-19 mRNA Vaccine 10micrograms/0.2ml dose concentrate for dispersion for injection multidose vials (Pfizer-BioNTech)  ⧠ Comirnaty Original/Omicron BA.1 COVID-19 mRNA Vaccine 15micrograms/15micrograms/0.3ml dose dispersion for injection multidose vials (Pfizer Ltd)  ⧠ Comirnaty Original/Omicron BA.4-5 COVID-19 mRNA Vaccine 15micrograms/15micrograms/0.3ml dose dispersion for injection multidose vials (Pfizer Ltd)  ⧠ Comirnaty Children 6 months - 4 years COVID-19 mRNA Vaccine 3micrograms/0.2ml dose concentrate for dispersion for injection multidose vials (Pfizer Ltd)  ⧠ COVID-19 Vaccine Spikevax 0 (Zero)/O (Omicron) 0.1mg/ml dispersion for injection multidose vials (Moderna, Inc)  ⧠ COVID-19 Vaccine Spikevax Original/Omicron BA.4/BA.5 dispersion for injection 0.1mg/ml multidose vials (Moderna, Inc)  ⧠ COVID-19 Vaccine VidPrevtyn Beta (CoV2 preS dTM monovalent B.1.351 [recombinant adjuvanted]) 5micrograms/0.5ml dose solution and emulsion for emulsion for injection multidose vials (Sanofi Pasteur) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Batch Number\* |  |  | |  | |  | |  | |  | |  | |  |  | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Manufacturer’s expiry date\* |  |  | | / | |  | |  | |  | | / | |  |  | |  | |  | | DD/MMM/YYYY – 01/JAN/2000 | | | | | | | | | | | | | |
| Use by date\* |  |  | | / | |  | |  | |  | | / | |  |  | |  | |  | | DD/MMM/YYYY – 01/JAN/2000 | | | | | | | | | | | | | |
| Administration Site\* | ⧠ Left deltoid  ⧠ Right deltoid  ⧠ Left thigh  ⧠ Right thigh | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Route of administration\* | ⧠ Intramuscular | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Any adverse effects\* | ⧠ None Observed  ⧠ Yes (please note details in notes section below) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Vaccine not given | |
| Dose sequence not given | ⧠ First Administration  ⧠ Second Administration |
| Reason vaccine not administered | ⧠ Generally feeling unwell / Symptomatic  ⧠ Contraindications / Clinically not suitable  ⧠ Consent not given |

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| Notes | |
| Clinical notes  e.g. adverse reactions |  |

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| Vaccination Location | |
| Location Type | ⧠ Onsite at a Hospital Hub  ⧠ Onsite at a PCN LVS  ⧠ Onsite at a Pharmacy run LVS  ⧠ Onsite at a Vaccination Centre  ⧠ Roving at a detained setting  ⧠ Roving at a Care Home  ⧠ Roving at a Residential Facility  ⧠ Home of Housebound Patient  ⧠ Not Recorded |

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| Vaccinator | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Surname\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Professional body registration no.\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature\* |  | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Vaccine Drawer | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Surname\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Responsible Drawer First Name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Responsible Drawer Surname |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Professional body registration no.\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature\* |  | | | | | | | | | | | | | | | | | | | | | | | | | |

If drawer is not registered with a professional body, please capture Responsible drawer name and registration

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| For Care Home use only | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CQC Number |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Care Home Name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Care Home Postcode |  |  |  |  |  |  |  |  |  | | | | | | | | | | | | | | | | | |

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| For Residential Facility use only | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Residential Facility Name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Residential Facility Address |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Residential Facility Post Code |  |  |  |  |  |  |  |  |  | | | | | | | | | | | | | | | | | |

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| Notes continued | |
| Clinical notes continued  e.g. adverse reactions |  |