Please record your vaccinations using this form if the service is temporarily unavailable.

Asterisk (\*) indicates a mandatory field.

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| Your location | | | | | | | | | | | | | | | | | | | | | |
| Organisation name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Site\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Care model\* | Hospital hub  Vaccination centre  Care home  Home of housebound patient  Off-site outreach event | | | | | | | | | | | | | | | | | | | | |
| If **you selected** **care home**, please confirm the following details: | | | | | | | | | | | | | | | | | | | | | |
| Organisation name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Address\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Postcode\* |  |  |  |  |  |  |  |  |  | | | | | | | | | | | | |
| ODS Code\* |  |  |  |  |  |  | | | | | | | | | | | | | | | |

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| Patient’s details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name\* |  |  | |  | |  | |  | |  | |  |  |  |  |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  |
| Last name\* |  |  | |  | |  | |  | |  | |  |  |  |  |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  |
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| NHS number |  |  | |  | |  | |  | |  | |  |  |  |  |  | |  | |  | | | | | | | | | | | | | | | | |
| Date of birth\* |  |  | | / | |  | |  | | / | |  |  |  |  | DD/MM/YYYY | | | | | | | | | | | | | | | | | | | | |
| Gender | Male  Female  Other  Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Telephone |  | |  | |  | |  | |  | |  |  |  |  |  | |  | |  | |  | |  | | | | | | | | | | | | | |
| Address\* |  | |  | |  | |  | |  | |  |  |  |  |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  |  |
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| Postcode |  | |  | |  | |  | |  | |  |  |  |  | | | | | | | | | | | | | | | | | | | | | | |

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| Choose vaccine | | |
| Select which vaccine the patient wants to receive\* | COVID-19 | Flu |
| Vaccine\* | Comirnaty Original/Omicron BA.4-5  Comirnaty 30 Omicron XBB.1.5  Comirnaty 3 Omicron XBB.1.5  Comirnaty 10 Omicron XBB.1.5  Spikevax XBB.1.5 | Fluenz Tetra – LAIV  Sanofi Pasteur  Quadrivalent Influenza Vaccine – QIVe  Supemtek – QIVr  Seqirus  Flucelvax Tetra – QIVc  Fluad Tetra – aQIV  Quadrivalent Influvac Sub – unit Tetra - QIVe |

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| Assess the patient | | | | | | | | | | | | |
| Check the patient is suitable for vaccination | | | | | | | | | | | | |
| Is the patient eligible for the vaccine?\* | Yes | | | | | | | | | No | | |
| If y**ou selected** **yes**, please select the first relevant eligibility type: | | | | | | | | | | | | |
| Eligibility type\* | Residents in care homes  Staff working in care home  Healthcare workers  Social care workers  Age-based eligibility  Pregnancy  People with immunosuppression  People in other clinical risk groups  People who are homeless or live in closed settings like supported living accommodation  Household contacts of people with immunosuppression  Carer  People that have had CAR-T therapy or stem cell transplantation since receiving their last vaccination | | | | | | | | | | | |
| If **you selected healthcare workers**, please select the staff role: | | | | | | | | | | | | |
| Staff role\* | Doctor  Qualified nurse/midwife  All other professionally qualified clinical staff  Clinical support  Non-clinical | | | | | | | | | | | |
| Assessment date\* |  |  | / |  |  | / |  |  |  | |  | DD/MM/YYYY |
| Assessment outcome\* | Give vaccine | | | | | | | | | Vaccine not given | | |
| Comments (optional) |  | | | | | | | | | | | |
| If the **vaccine was not given**, please give a reason: | | | | | | | | | | | | |
| Reason vaccine not given\* | Not appropriate to vaccinate today, patient advised to rebook  Patient declined  Vaccine contraindicated | | | | | | | | | | | |

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| Assessing clinician | | | | | | | | | | | | | | | | | |
| First name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Last name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Professional body registration name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Professional body registration number\* |  |  |  |  |  |  |  |  | | | | | | | | | |
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| Record consent | | | | | | | | | | | | | | | | | | |
| Does the patient or someone on their behalf consent to the vaccination?\* | Yes, they consent | | | | | | | | | No | | | | | | | | |
| If y**ou selected yes**, **they consent**, please confirm who gave consent: | | | | | | | | | | | | | | | | | | |
| Consent given by\* | Patient (informed consent)  Person with parental responsibility  Court appointed deputy  Independent mental capacity advocate  Clinician following the Mental Capacity Act (in the patient’s best interests)  Person with lasting power of attorney for personal welfare | | | | | | | | | | | | | | | | | |
| If **someone on behalf of the patient gave consent**, please complete their details: | | | | | | | | | | | | | | | | | | |
| Name of the person consenting\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |
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| Relationship to the patient\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |
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| If **no** **consent was given**, please confirm the reason: | | | | | | | | | | | | | | | | | | |
| No consent reason\* | Having elsewhere/had vaccination  Other  Personal choice  Porcine (pork) | | | | | | | | | | | | | | | | | |

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| Consenting Clinician | | | | | | | | | | | | | | | | | |
| Is this the same person as the assessing clinician?\* | Yes | | | | | | | | | No | | | | | | | |
| If **you selected** **no**, please confirm the consenting clinician's details: | | | | | | | | | | | | | | | | | |
| First name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Last name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Professional body registration name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Professional body registration no.\* |  |  |  |  |  |  |  |  | | | | | | | | | |
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| Vaccinate | | | | | | | | | | | | | | | | | | | | | | |
| Have you vaccinated the patient?\* | Yes | | | | | | | | | | | | | | | | | | No | | | |
| Vaccination date\* |  |  | | / | |  | |  | | / | |  | |  | |  | |  | | | DD/MM/YYY | |
| If the **vaccine was not given**, please confirm the reason: | | | | | | | | | | | | | | | | | | | | | | |
| No vaccination reason\* | Not appropriate to vaccinate today, patient advised to rebook  Patient declined  Vaccine contraindicated | | | | | | | | | | | | | | | | | | | | | |
| If the v**accine was given**, please complete the details below: | | | | | | | | | | | | | | | | | | | | | | |
| Vaccine\* | Comirnaty Original/Omicron BA.4-5  Comirnaty 30 Omicron XBB.1.5  Comirnaty 3 Omicron XBB.1.5  Comirnaty 10 Omicron XBB.1.5  Spikevax XBB.1.5  Fluenz Tetra – LAIV  Sanofi Pasteur  Quadrivalent Influenza Vaccine – QIVe  Supemtek – QIVr  Seqirus  Flucelvax Tetra – QIVc  Fluad Tetra – aQIV  Quadrivalent Influvac Sub – unit Tetra - QIVe | | | | | | | | | | | | | | | | | | | | | |
| Vaccination route\* | Left upper arm  Right upper arm  Left buttock  Right buttock  Left thigh  Right thigh  Nasal  Oral | | | | | | | | | | | | | | | | | | | | | |
| Batch number\* |  | |  | |  | |  | |  | |  | | - | |  | |  | | |  | |  |
| Batch expiry date\* |  | |  | | / | |  | |  | | / | |  | |  | |  | | |  | | DD/MM/YYYY |
| Dose amount (ml)\* |  | |  | |  | |  | |  | | | | | | | | | | | | | |
| Prescribing method\* | National Protocol (NP)  Patient Group Directions (PGD)  Patient Specific Directions (PSD) | | | | | | | | | | | | | | | | | | | | | |

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| Vaccinator | | | | | | | | | | | | | | | | | |
| Is this the same person as the assessing and consenting clinician?\* | Yes | | | | | | | | | No | | | | | | | |
| If y**ou selected no**, please confirm the vaccinator's details: | | | | | | | | | | | | | | | | | |
| First name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Last name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Professional body registration name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Professional body registration no.\* |  |  |  |  |  |  |  |  | | | | | | | | | |
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