Seasonal **Influenza** Community Pharmacy Vaccination Service (Flu-CPVS)
Vaccination Record Form - Please complete the following:

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Note: Payment cannot be claimed via this paper form. All payments are made following VMS submission

Patient has confirmed they have not had an influenza vaccination already administered by another provider ☐

Section 1.	**Patient details**		
First Name:		**Family Name:**	
Registered GP Practice		**Date of Birth:**	
Health and Care Number:		**Gender at birth:**	**Male** ☐ **Female** ☐
Address:			
Town/City:		**Postcode:**	
Mobile Number:		**Email Address:**	

Section 2a	**Patient Cohort**
Cohort	**Aged 65 yrs or over** ☐ **18-64 yrs in clinical risk group** ☐ **Carer** ☐ **Immunosuppressed** ☐ **Household contact of immunosuppressed** ☐ **Pregnancy** ☐ **Care home resident** ☐ **Care home staff** ☐ **RQIA Care Home number** ☐

Section 2b	**Health & Social Care Worker (HSCW)**		**Yes** ☐ **No** ☐
Trust HSCW Employer	**Belfast HSCT** ☐	**Northern HSCT** ☐	**South Eastern HSCT** ☐
	Southern HSCT ☐	**Western HSCT** ☐	**Northern Ireland Ambulance** ☐
Non- Trust HSCW Employer	**Hospice** ☐	**Primary Care** ☐	**Community Provider** ☐
	Regional Organisation ☐	**Private** ☐	**NI Blood Transfusion Service** ☐
	Other ☐	**Care home staff** ☐	**RQIA Care Home number** ☐

Section 3.	**Vaccine Safety Check & Consent**	
Vaccine Safety Check	Is the patient currently unwell with a high temperature or fever?	Yes ☐ No ☐
	Has the patient ever had a severe allergic reaction to a Flu vaccine in the past?	Yes ☐ No ☐
	Has the patient ever had a severe allergic reaction (requiring hospital treatment/care) to any vaccine components (eggs or egg products, latex, gentamycin/neomycin or formaldehyde)?	Yes ☐ No ☐
	Does the patient suffer from severe asthma (requiring hospital treatment/care) or have had increased wheezing and/or needed addition reliever (bronchodilator) doses in the past 3 days?	Yes ☐ No ☐
	Does the patient have a bleeding disorder, or is currently taking anticoagulant medication (e.g. Warfarin, Apixaban, etc.)?	Yes ☐ No ☐

Proceed to Vaccinate:	Yes ☐ No ☐	If no, state reason	

Patient consents and is content pharmacist confirms declaration on their behalf. (TICK TO CONFIRM)	Yes ☐

Section 4.	**Vaccination Details**		
Name / Dose / Form of Influenza Vaccine:	**aQIV – Fluad Tetra 0.5ml** ❑ **or** **QIVc – Flucelvax 0.5ml** ❑	**Date of vaccination:**	
		Route of Administration:	**IM** ☐
Batch number:		**Expiry Date:**	
Injection Site:	**Left Arm** ☐ **Right Arm** ☐ **Left Thigh** ☐ **Right Thigh** ☐		
Any Adverse Effects		**Advice given**	
Administered by (Vaccinator Name)		**Signature**	