**VACCINATION OF CARE HOME RESIDENTS REQUIRING BEST INTERESTS INFORMATION**

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| **Practice number** ­­­­­­­­­­­­­­­­­­ |  | | |
| **Practice name** ­­­­­­­­­­­­­­ |  | **Practice address** |  |
|  |  |
| **Care home name** |  | **Care Home Address­­­­­­­­­** |  |
|  |
| **Signature of GP­­­­­­­­­­­­­­­­­­­­** | | | |

The following patients are registered with this practice. Please can you complete the information requested below to assist the vaccinating pharmacist make a best interest decision.

|  | Name | Date of Birth | Health & Care number | History of significant allergy  **YES/NO** | Information known to GP that vaccination may **not** be in best interests  **NONE or give details of information** |
| --- | --- | --- | --- | --- | --- |
| 1 |  |  |  |  |  |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |
| 4 |  |  |  |  |  |
| 5 |  |  |  |  |  |
| 6 |  |  |  |  |  |