Individual Patient Assessment to Administer Influenza Vaccination

or Pfizer BionNTech COVID-19 mRNA Vaccine BNT 162b2

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| --- | --- |
|  | **Patient Details – please complete as best you can**  |
| **First Name:** | **Surname:**  |
| **Mobile number:**  | **NHS Number:**  |
| **D.O.B:** | **Postcode:** | **Gender: Male Female**  |
| **Priority vaccination groups (*please circle or tick any that apply to you*)** |
| **Carer** | **Health or care worker**  | **Care Home worker**  |
| **Care worker**  | **Clinically Vulnerable**  | **Lives with Clinically vulnerable**  |

|  |  |
| --- | --- |
|  | **Monitoring data (*please circle or tick any that apply to you*)** |
| White British  | Mixed White Afro Caribbean | Asian/Asian British | Black/Black British Caribbean  |
| White Irish | Mixed White Black African  | Chinese  | Black/Black British African  |
| White other  | Mixed White Asian  | Mixed other | Black/Black British Other  |

**Vaccination suitability check** *(mandatory)*

# Tick each box below if statement is true

* I haven’t had a **cough or high temperature** or other **COVID symptoms** in the last 7 days
* I haven’t received **any other vaccination** in the last 7 days
* I have not had an **allergic reaction to egg or chicken** protein

* I have not had any previous **unexplained anaphylaxis**
* I have not previously suffered any **serious allergic reactions**/I do not carry an **Epi Pen**
* I’m not / don’t think I am **pregnant or breast feeding**
* I have not taken part in any **trials** of any COVID vaccine
* I haven’t got any history of **blood clots or clotting disorders**
* I am not currently taking **anticoagulation** medicines / I do not suffer from any **bleeding disorder**

***If you have any questions or are struggling with this form, just let a member of staff know and they will help you.***

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| --- | --- | --- |
|  | **Consent** | Tick as appropriate  |
| Consent given for vaccination by patient  |  |
| Consent provided by third party (POA, Appointed Deputy, Clinician as a Best Interest (need Best Interest form completed)  |  |

|  |  |  |
| --- | --- | --- |
|  | **Outcome** | Initial as appropriate |
| Ready to be vaccinated  |  |
| Needs to be seen by clinical lead before any possible vaccination  |  |

Admin use only

|  |  |  |
| --- | --- | --- |
|  | **Vaccine administration**  |  |
| Vaccine batch number  |
| Pre-screener  |  |
| Vaccinator |  |
| Date  |  |

|  |
| --- |
| **Health Checks**  |
| We are seeking to carry out health checks for all patients aged over 50 years or who are aged over 16 and extremely clinically vulnerable. This will enable to us to help you detect health issues that you may have but are unaware of. We are doing thses checks while you are under clinical observation in line with the national vaccination rules so it will take no extra time out of your day. Just let us know if you do not wish to have a health check.  |
| **Height** | **Weight** |
|  |  |
| **Waist Circumference (in centimetres)** | **BMI** |
|  |  |
| **Blood Pressure** | **Pulse (reg/irregular)** |
|  |  |
| **Smoking Status** | **Stop Smoking Services Signposted** |
| I have never smoked  I am a Smoker:Trivial (Less than 1 per day) Light (1-9 per day) Moderate (10-19 per day) Heavy (20-39 per day) Very Heavy (40+) I am an Ex-Smoker:Trivial (Less than 1 per day) Light (1-9 per day) Moderate (10-19 per day) Heavy (20-39 per day) Very Heavy (40+)  |  |
| **Alcohol** | **How Many Units per week?** |
| **Do you drink alcohol?****Yes**  **No**  |  |
| **Notes**  |
|  |

***Thank you for completing this form – we really appreciate it!***

***Please hand the completed form to one of our Team.***