South Tyneside Council Pharmacy Seasonal Influenza Vaccination Service - Record & Consent Form

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| **Patient’s details** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name\* |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  | |  |  | |  |
| Surname\* |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  | |  |  | |  |
| Address |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  | |  |  | |  |
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| Postcode |  | |  |  |  |  |  |  |  |  | | | | | | | | | | | | | | | | |
| Telephone |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  | |  |  | |  |
| Date of birth\* |  | |  |  |  | NHS Number | | | | |  |  |  |  | |  |  |  | |  |  | |  |  | |  |
| GP practice\* |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  | |  |  | |  |
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| **Council Staff Service Extra Details** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  South Tyneside Place of Work / ID No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If council Staff please record which team \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Where you vaccinated last year Yes **☐** No**☐**  If yes where Pharmacy **☐** GP ☐ Occupational Health ☐  Other ☐ Please State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Patient consent** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. I agree to be given a flu vaccination by a trained pharmacist. 2. I confirm I have not already received a flu vaccination for this flu season. 3. I declare that the information I have given on this form is correct and complete. 4. I consent to the disclosure of relevant information, where appropriate, from this form to:  * my GP practice to help them provide care to me; and * South Tyneside Council & NHS England (the national NHS body that manages pharmacy and other health services) for the purposes of checking payments to the pharmacy and to allow them to make sure the service is being provided properly. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature | |  | | | | | | | | | | | | | Date | | | |  | | |  | | |  | |

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| **To be completed by pharmacy staff** | | | | | | | | | | | | | | | | | | |
| Any allergies | |  | | | | | | | | | | | | | | | | |
| Eligible patient group\* | | Aged over 65 | | | | | | Chronic respiratory disease | | | | | | | | | | |
| Chronic heart disease | | | | | | Chronic kidney disease | | | | | | | | | | |
| Chronic liver disease | | | | | | Chronic neurological disease | | | | | | | | | | |
| Diabetes | | | | | | Immunosuppression | | | | | | | | | | |
| Splenic dysfunction | | | | | | Pregnant woman | | | | | | | | | | |
| Person in long-stay residential or home | | | | | | Carer | | | | | | | | | | |
| Household contact of immunocompromised individual | | | | | | | | | | | | | | | | |
| **Vaccination details** | | | | | | | | | | | | | | | | | | |
| Name of vaccine/ manufacturer\* | Apply vaccine sticker if available | | | Date of vaccination\* | |  |  | | |  | Pharmacy stamp | | | | | | | |
| Batch  Number\* |  | | | Injection site\* | | Left upper arm    Right upper arm | | | | |  | | | | | | | |
| Expiry  Date\* |  | | | Route of administration\* | | Intramuscular    Subcutaneous | | | | |
| Any adverse effects\* |  | | | | | | | | | | | | | | | | | |
| Advice given and any other notes |  | | | | | | | | | | | | | | | | | |
| Administered by\*  (pharmacist name) |  | | Signature\* | |  | | | | GPhC number\* | | |  |  |  |  |  |  |  |