Community Pharmacy IM Flu Vaccination Consultation Form 2013/14

1. Patient Details

Date of Consultation ……/……/……..

Patient Date of Birth ……/……/……..

GP Practice ……

(Please include address) ……

Ethinicity ……

Name

Address

Postcode
Cover with PMR Bag Label

Mobile No:

2. Referral Method

Patient Self Referral ☐ Pharmacist ☐ GP Surgery ☐ Other ☐

Did you receive a Flu vaccination last year? Yes ☐ No ☐ ------- If Yes, Was it in a pharmacy? Yes ☐ No ☐

3. Eligibility for NHS flu vaccine

Over 65 years of age ☐ Pregnant ☐ Respiratory Disease ☐ Heart Disease ☐ Liver Disease ☐ Kidney Disease ☐
Neurological Disease ☐ Diabetes Mellitus ☐ Main Carer ☐ Immunosuppressed ☐ Long Stay Res./Nursing Home ☐
Not Eligble / Private Vaccination ☐

(Please note, risk group should be verified either by patient letter from GP/LASCA inviting the patient for flu vaccination Or where appropriate by reviewing PMR in discussion with the patient. Pregnancy can be verified by pregnancy notes or discussion with patient.)

Verified by: GP/LAT Letter ☐ PMR ☐ Contacted GP Practice ☐ Other ..... ☐

5. Medical History

Is the patient aged under 18? Yes ☐ No ☐ (If yes refer patient to GP for Nasal Vaccination)
Is the patient well today? [minor colds and coughs are not exclusions] Yes ☐ No ☐

Any Medical Conditions _____

Current Medication _____

Allergies _____

Vaccine NOT GIVEN ☐ To return another day ☐ Referred to GP ☐

5. To be completed by the Patient

☐ I confirm that I have not had a flu vaccine this year
☐ I have been informed and understand the benefits and possible side effects of the flu vaccine.
☐ I give permission to send a copy of this consultation form to NHS England and my GP to update my records
☐ I consent to receiving the flu vaccine.

Signature _____ Date _____

6. Record of vaccine administered (to be completed by pharmacist)

Brand (peel off label)

Batch No (peel off label)

Expiry Date
Injection site Left ☐ / Right ☐ Deltoid

Vaccine Label

Pharmacy Name
Address

Postcode
Tel No.

Stamp can be used.

Pharmacist Name _____

Pharmacist Signature _____ Date _____/_____/_____

Encourage Patient to complete survey before leaving pharmacy
Please fax this completed consultation form to the patient's GP immediately after the consultation

7. Record of vaccine administered (to be completed by GP practice)

Please use **READ code 65E20** when updating the patient's details.

Pharmacy Tick as Complete :- Send to GP ☐ PMR Flag ☐ Pharm. Copy ☐ Pharmoutcomes ☐

PHARMACY ADMINISTERED FLU VACCINATION – PATIENT EXPERIENCE SURVEY

We would be very interested to know your views on this service.

Date of birth:_____ Date of Vaccination _____

Please state the reason for having the vaccine (please tick)

Over 65	☐	Chronic Respiratory Disease	☐	Chronic Kidney Disease	☐
Diabetes	☐	Chronic Heart Disease	☐	Immunosuppression	☐
Main Carer	☐	Chronic Neurological Disease	☐	Chronic Liver Disese	☐
Pregnant	☐	Longstay Residential Home	☐	Private	☐

1. **Where did you get your Vaccine from last year?**
   1st Time Vaccine ☐ Pharmacy ☐ GP ☐ Other ☐ _____

2. **How satisfied were you with the service you received in the pharmacy?**
   Extremely satisfied ☐ Very satisfied ☐ Satisfied ☐ Not Satisfied ☐

3. **Was the flu vaccination administered as well by the pharmacist, as by other health care professionals in the past? e.g. GP or nurse?**
   Yes ☐ No ☐

4. **Do you feel that a pharmacy is an appropriate place to receive an immunisation?**
   Yes ☐ No ☐

5. **Would you use this service again in the future to receive your flu vaccination?**
   Yes ☐ No ☐

6. **Would you be happy to have other vaccinations administered by a pharmacist in the future?**
   Yes ☐ No ☐

7. **What did you like best about this service?**
   Close to home ☐ No need for an appointment ☐
   Convenient opening times ☐ Convenient location near shops/work ☐
   Other ☐ Please State _____

8. **How did you hear about this service?**
   From pharmacist ☐ Poster in pharmacy ☐ Newspaper ☐
   From GP/Nurse ☐ Poster in surgery ☐ Word of mouth ☐
   Used it last year: ☐ Other ☐ Please State _____

Many thanks for your time in completing this survey

PHARMACY
the Heart of our Community