**Annex E NHS Flu Vaccination Service - Record Form**

\* indicates sections that must be completed

|  |
| --- |
| **Patient’s details** |
| First name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Surname\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Address\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Postcode |  |  |  |  |  |  |  |  |  |
| Telephone |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Date of birth\* |  |  |  |  |  |  | NHS No. |  |  |  |  |  |  |  |  |  |  |  |  |
| GPpractice\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Patient’s emergency contact** |
| Name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Telephone |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Relationship to patient |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Any allergies |  |
| Eligible patient group\* | 65 years or over | Chronic respiratory disease |
|  | Chronic heart disease | Chronic kidney disease |
|  | Chronic liver disease | Chronic neurological disease |
|  | Diabetes | Immunosuppression |
|  | Asplenia / splenic dysfunction | Pregnant woman |
|  | Person in long-stay residential care home or care facility | Carer |
|  | Household contact of immunocompromised individual | Morbid obesity (BMI ≥ 40) |
|  | 50-64 years (not in risk group) | Learning disability |
|  | Household contact of person on NHS shielded patient list | Employed through Direct Payment of Personal Health Budget |
|  | Social care worker | Hospice worker |

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| --- |
| **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 |
| Location (if notin the pharmacy)\* | Patient’s homeLong-stay care home or long-stay residential facility Other location (please state): |
| Any adverseeffects\* |  |
| Advice given and any othernotes |  |
| Administeredby\* |  | Signature\* |  | Registrationnumber |  |  |  |  |  |  |  |