

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*																			
GP practice*																			
Patient's emergency contact																			
Name																			
Telephone																			
Relationship to patient																			
Any allergies																			
Eligible patient group*	<input type="checkbox"/> 65 years or over									<input type="checkbox"/> Chronic respiratory disease									
	<input type="checkbox"/> Chronic heart disease									<input type="checkbox"/> Chronic kidney disease									
	<input type="checkbox"/> Chronic liver disease									<input type="checkbox"/> Chronic neurological disease									
	<input type="checkbox"/> Diabetes									<input type="checkbox"/> Immunosuppression									
	<input type="checkbox"/> Asplenia / splenic dysfunction									<input type="checkbox"/> Pregnant woman									
	<input type="checkbox"/> Person in long-stay residential care home or care facility									<input type="checkbox"/> Carer									
	<input type="checkbox"/> Household contact of immunocompromised individual									<input type="checkbox"/> Morbid obesity (BMI ≥ 40)									
	<input type="checkbox"/> 50-64 years (not in risk group)									<input type="checkbox"/> Learning disability									
	<input type="checkbox"/> Household contact of person on NHS shielded patient list									<input type="checkbox"/> Employed through Direct Payment of Personal Health Budget									
	<input type="checkbox"/> Social care worker									<input type="checkbox"/> Hospice worker									

Vaccination details

Name of vaccine/ manufacturer*	Apply vaccine sticker if available	Date of vaccination*				Pharmacy stamp				
Batch Number*		Injection site*	<input type="checkbox"/> Left upper arm <input type="checkbox"/> Right upper arm							
Expiry Date*		Route of administration*	<input type="checkbox"/> Intramuscular <input type="checkbox"/> Subcutaneous							
Location (if not in the pharmacy)*	<input type="checkbox"/> Patient's home <input type="checkbox"/> Long-stay care home or long-stay residential facility <input type="checkbox"/> Other location (please state):									
Any adverse effects*										
Advice given and any other notes										
Administered by*		Signature*		Registration number						