APPENDIX 13

Assessment for the Supply and Administration of Hepatitis B Vaccination (Ultra Rapid Course)

Pharmacy Stamp	**Client's Name**	
	Date of Consultation	
	Date of Birth (Age)	
GP name and address	**Mobile Phone Number for SMS**	
	Post Code	

Criteria for Inclusion	Yes	No	Notes
Injecting Drug User, their sexual partners, injecting partners and domestic contacts over the age of 18.			

If further advice is required refer client to Sexual Health Service

Criteria for Referral (Exclusion)	Yes	No	Notes
Patient less than 18 years			If Yes Refer
Does the patient suffer from acute febrile illness			If Yes Refer
Has the Patient been confirmed as Hep B positive			If Yes Refer
Is patient HIV positive or immunosuppressed			If Yes Refer
Has the patient ever suffered an allergic reaction to the vaccine or any component of the vaccine			If Yes Refer
Is the patient allergic to eggs (remember to ask about cake and biscuits)			If Yes Refer
Has the patient been confirmed as pregnant or breastfeeding			If Yes Refer
Is the patient currently receiving treatment for post exposure prophylaxis			If Yes Refer

Counselling	Yes	No
Explain schedule of vaccination and emphasis importance of completing the vaccination course		
Give appointments for 2nd and 3rd vaccine and explain SMS messaging if appropriate		
Provide patient with vaccination card detailing schedule i.e. 0,7, and 21 days.		
Explain the need to dry blood spot test for Hep B and Hep C		
Explain common side effects i.e. injection site pain, erythema, injection site induration. Mention less common side effects-anaphylaxis		
Check Client ID		
Offer safer sex advice and condoms (see leaflets)		

Other Notes

Day of Request													
Mon		Tue		Wed		Thu		Fri		Sat		Sun	

Counselling, Recording and Consent

Patient Declaration: The above information is correct to the best of my knowledge. I have been fully informed on the importance of Hepatitis B vaccination, potential side effects and the importance of completing the course. My signatures below give my consent to perform testing for Hepatitis B and C and for administration of this course of vaccination.

Carry Out Dry Blood Spot Testing for Hepatitis B and Hepatitis C		Yes:	No:
Client Signature	Pharmacist Signature:	Date:	

Vaccination 1 (day 0) **/ Booster (delete as appropriate)** – If Booster remember to check no *change in circumstances that prevents vaccination*

Engerix B prefilled syringe 20mcg/1ml administered in pharmacy		Yes:	No:
Batch No:	Expiry:	Actual Day No: 0	
Client Signature	Pharmacist Signature:	Date:	
Date of next dose confirmed and entered on SMS system?		Yes:	No:

Vaccination 2 (day 7) – *Reminder: Check no change in circumstances, e.g. pregnancy or anaphylaxis to Vaccine 1*

Engerix B prefilled syringe 20mcg/1ml administered in pharmacy		Yes:	No:
Batch No:	Expiry:	Actual Day No:	
Client Signature	Pharmacist Signature:	Date:	
Date of next dose confirmed and entered on SMS system?		Yes:	No:

Vaccination 3 (day 21) – *Reminder: Check no change in circumstances, e.g. pregnancy*

Engerix B prefilled syringe 20mcg/1ml administered in pharmacy		Yes:	No:
Batch No:	Expiry:	Actual Day No:	
Client Signature	Pharmacist Signature:	Date:	
Chlamydia Test Kit provide if appropriate (Target Age 18-25)		Yes:	No:

Client Consent To Inform G.P and/or IDAS where appropriate of completion of vaccine course		
Client Signature:	Pharmacist Signature:	Date:

NB: Please retain this form to record vaccines 2 and 3 and any booster. Claims should be made on the monthly claim form for each encounter- available for download from the LPC Website.