

COVID-19 Vaccination - eVacc Offline Form

Basic Information			
First Name(s)		Last Name	
Date of Birth		Telephone	
Postcode		Address	
GP Practice		NHS Number	
Tick any that apply to the patient	<input type="checkbox"/> Works in a residential care home for older people <input type="checkbox"/> Carer <input type="checkbox"/> Social Care Worker <input type="checkbox"/> Healthcare Worker <input type="checkbox"/> Lives in a residential care home		

Screening & Consent	
Patient Screened by	
Care Setting Type	<input type="checkbox"/> Onsite <input type="checkbox"/> Home of Housebound Patient <input type="checkbox"/> Roving at a Care Home <input type="checkbox"/> Roving at Residential Facility <input type="checkbox"/> Roving at a Detained Setting
12-15 year old vaccine	Is the patient clinically extremely vulnerable or a household contact of an immunosuppressed individual? <input type="checkbox"/> Yes <input type="checkbox"/> No
Vaccine Type	<input type="checkbox"/> AstraZeneca <input type="checkbox"/> Comirnaty® (PfizerBioNtech) <input type="checkbox"/> Spikevax® (Moderna)
Exclusions <i>Please tick all that apply to the patient</i>	<input type="checkbox"/> Have you experienced major venous and/or arterial thrombosis occurring with thrombocytopenia following vaccination with any COVID-19 vaccine? <input type="checkbox"/> Has the individual had any vaccination in the last 7 days? <input type="checkbox"/> Is the individual currently unwell with fever? <input type="checkbox"/> Has the individual ever had any serious allergic reaction to any ingredients of the Covid-19 vaccines, drug or another vaccine? <input type="checkbox"/> Has the individual ever had an unexplained anaphylaxis reaction? <input type="checkbox"/> Does the individual have a history of heparin-induced thrombocytopenia and thrombosis (HITT or HIT type 2)?
Cautions <i>Please tick all that apply to the patient</i>	<input type="checkbox"/> Has the individual indicated they are, or could be pregnant? <input type="checkbox"/> Has the individual informed you are currently or have been in a trial of a potential coronavirus vaccine? <input type="checkbox"/> Is the individual taking anticoagulant medication, or do you have a bleeding disorder? <input type="checkbox"/> Does the individual currently have any symptoms of Covid-19 infection?
Dose	<input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Booster
Safe to proceed?	<input type="checkbox"/> Yes <input type="checkbox"/> No (DO NOT PROCEED)
Protocol?	<input type="checkbox"/> National <input type="checkbox"/> PGD <input type="checkbox"/> PSD
Consent given?	<input type="checkbox"/> Yes <input type="checkbox"/> No (DO NOT PROCEED)
Consent given by	<input type="checkbox"/> Patient <input type="checkbox"/> Parent / Guardian <input type="checkbox"/> Court Appointed Deputy <input type="checkbox"/> Independent Mental Capacity Advocate <input type="checkbox"/> Healthcare Lasting Power of Attorney <input type="checkbox"/> Clinician using Best Intends Process of the Mental Capacity Act

Vaccine Administration		
Vaccinated by		Date & Time
Batch No. & Type		Expiry Date
Drawn up by		Resp. Drawer
Injection Site	<input type="checkbox"/> Left Arm <input type="checkbox"/> Right Arm <input type="checkbox"/> Other, please specify:	
Successfully completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, please indicate reason:

FOR CAREHOME USE ONLY									
CQC Number									
Care Home Name									
Postcode									

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