Flu Vaccination - eVacc Offline Form

Basic Information			
First Name(s) Last Name		Date of Birth	
Postcode		Address	
GP Practice		NHS Number	

Screening & Consent	
Patient Screened by	
Care Setting Type	**At clinical risk group** ☐ Over 50 ☐ Pregnant ☐ Chronic Respiratory Disease ☐ Chronic Heart Disease ☐ Chronic Kidney Disease ☐ Chronic Liver Disease ☐ Chronic Neurological Disease ☐ Diabetes ☐ Immunosuppression ☐ Asplenia/splenic dysfunction ☐ Learning Disability ☐ Morbid Obesity (BMI>40) **Occupation** ☐ Healthcare or Social care worker ☐ Hospice worker ☐ Carer ☐ Employed through Direct Payment of Personal Health Budget **Other** ☐ Household contact of person on NHS shielded patient list ☐ Clinician`s discretion **Not Eligible** ☐ Not Eligible for National Immunisation Programme Reimbursement
Vaccine Type	☐ AstraZeneca - Fluenz Tetra vaccine nasal suspension 0.2ml ☐ Seqirus-Fluad Tetra vaccine inj 0.5ml pre-filled syringes ☐ Seqirus- Flucelvax Tetra vacc inj 0.5ml pre-filled syringes ☐ Sanofi Pasteur - Quadrivalent Flu/Vac/Split inj 0.5ml pfs ☐ Sanofi Pasteur - Supemtek Quadrivalent vaccine (recombinant) inj 0.5ml pfs ☐ Viatris - influvac sub-unit Tetra vacc inj 0.5ml pre-filled syringes
Exclusions	☐ Is the individual currently unwell with fever and/or systemic upset? ☐ Has the individual had a confirmed anaphylactic reaction to a previous dose of the influenza vaccine or to any component of the vaccine (other than egg)?
Cautions *Please tick all that apply to the patient*	☐ Does the individual have an egg allergy? ☐ Does the individual have a bleeding disorder, receive medication / treatment to reduce bleeding or are they on anticoagulation therapy? ☐ Has the individual ever had an unexplained anaphylaxis reaction? ☐ Is the individual currently experiencing flu symptoms? ☐ Has the individual used antiviral agents in the last 48 hours?
Safe to proceed?	☐ Yes ☐ No (DO NOT PROCEED) — Notes:
Protocol?	☐ National Protocol ☐ PGD ☐ PSD
Consent given?	☐ Yes ☐ No (DO NOT PROCEED)
Consent given by	☐ Patient ☐ Parent / Guardian ☐ Court Appointed Deputy ☐ Independent Mental Capacity Advocate ☐ Healthcare Lasting Power of Attorney ☐ 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	☐ Left Arm ☐ Right Arm ☐ Other, please specify:		
Successfully completed?	☐ Yes ☐ No	If no, please indicate reason:	

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