eva

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	☐ Works in a residential care home for older people ☐ Carer ☐ Social Care Worker ☐ Healthcare Worker ☐ Lives in a residential care home		

Screening & Consent	
Responsible Clinician	
Reimbursement	Is the patient severely immunosuppressed? ☐ Yes ☐ No
Care Setting Type	☐ Onsite ☐ Home of Housebound Patient ☐ Roving at a Care Home ☐ Roving at Residential Facility ☐ Roving at a Detained Setting
12-15 year old vaccine	Is the patient clinically extremely vulnerable or a household contact of an immunosuppressed individual? ☐ Yes ☐ No
Vaccine Type	☐ AstraZeneca ☐ Comirnaty® (PfizerBioNtech) ☐ Spikevax® (Moderna) ☐ Comirnaty® Children 5-11 years (Paediatric Pfizer)
Exclusions *Please tick all that apply to the patient*	☐ Have you experienced major venous and/or arterial thrombosis occurring with thrombocytopenia following vaccination with any COVID-19 vaccine? ☐ Has the individual had any vaccination in the last 7 days? ☐ Is the individual currently unwell with fever? ☐ Has the individual ever had any serious allergic reaction to any ingredients of the Covid-19 vaccines, drug or another vaccine? ☐ Has the individual ever had an unexplained anaphylaxis reaction? ☐ Does the individual have a history of heparin-induced thrombocytopenia and thrombosis (HITT or HIT type 2)? ☐ Has the individual had any covid symptoms or tested positive to covid over the last 4 weeks? (18 years old>=) ☐ Has the individual had any covid symptoms or tested positive to covid over the last 12 weeks? (<=18 years old)
Cautions *Please tick all that apply to the patient*	☐ Has the individual indicated they are, or could be pregnant? ☐ Has the individual informed you are currently or have been in a trial of a potential coronavirus vaccine? ☐ Is the individual taking anticoagulant medication, or do you have a bleeding disorder? ☐ Does the individual currently have any symptoms of Covid-19 infection?

Dose	☐ First ☐ Second ☐ Booster	Notes:
Safe to proceed?	☐ Yes ☐ No (DO NOT PROCEED)	
Protocol?	☐ National ☐ 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:	

FOR CAREHOME USE ONLY	
CQC Number	
Care Home Name	
Postcode	

Entered into eVacc online on (date)............................ By...