

Patient Details

First Name		Last Name	
CHI Number (if known)		Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male
Patient Address and Postcode			
Date of Birth (DD/MM/YYYY)		Phone Number	
GP Address or Practice Code			

Screening and ConsentHas the patient received any vaccinations in the last 6 months? ☐ Yes ☐ No

If 'Yes' provide previous vaccination details

Vaccination Course	Dose Number	Date (DD/MM/YYYY)
		<input type="checkbox"/> Date is approximate

Today's Vaccination

☐ COVID-19 ☐ Flu ☐ Pneumococcal ☐ Shingles
☐ 4 in 1 – Pertussis|Diphtheria|Polio|Tetanus 'Other' vaccination type _____

Suitability for Vaccine

☐ Patient is Suitable ☐ Patient is NOT Suitable
Tick Reason 'Patient is NOT Suitable' ☐ Not well on the day due to acute symptoms
☐ Treatment deferred due to previously undeclared contraindications

Suitability Notes (optional)

--

Consent to Vaccination☐ Consent Given ☐ Consent NOT Given**Vaccination**

☐ Vaccination Was Administered ☐ Vaccination Was NOT Administered
If vaccine was not administered give reason ☐ Patient refused vaccine ☐ Other
If 'Other' describe reason _____

Product	Batch number	Dose Number	Method of administration	Site of administration
Vaccination Notes (optional)				

☐ Patient was directed to vaccination information and guidance

Immuniser Name		Signature		Date	
Professional Reg Number					