Use this form if the service is temporarily unavailable.

Asterisk (\*) indicates a mandatory field.

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| Patient’s details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name\* |  |  | |  | |  | |  | |  | |  |  |  |  |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  |
| Last name\* |  |  | |  | |  | |  | |  | |  |  |  |  |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  |
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| NHS number |  |  | |  | |  | |  | |  | |  |  |  |  |  | |  | |  | | | | | | | | | | | | | | | | |
| Date of birth\* |  |  | | / | |  | |  | | / | |  |  |  |  | DD/MM/YYYY | | | | | | | | | | | | | | | | | | | | |
| Gender | Male  Female  Other  Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Telephone |  | |  | |  | |  | |  | |  |  |  |  |  | |  | |  | |  | |  | | | | | | | | | | | | | |
| Address\* |  | |  | |  | |  | |  | |  |  |  |  |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  |  |
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| Postcode |  | |  | |  | |  | |  | |  |  |  |  | | | | | | | | | | | | | | | | | | | | | | |

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| Your organisation’s details | | | | | | | | | | | | | | | | | | | | | |
| Name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Delivery team or site\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Choose vaccine\* |
| **COVID-19:**  Comirnaty 30 JN.1  Comirnaty 10 JN.1  Comirnaty 3 JN.1  Spikevax JN.1 |
| **Flu**:  Quadrivalent Influenza Vaccine (QIVe)  Influenza Tetra MYL (QIVe)  Cell-based Quadrivalent Influenza Vaccine (QIVc)  Adjuvanted Quadrivalent Influenza Vaccine (aQIV)  Fluenz (LAIV)  ☐ Quadrivalent Influenza Vaccine - High-Dose (QIV-HD) |
| **Pertussis**:  Adacel vaccine suspension  Boostrix-IPV suspension  Repevax vaccine suspension |
| **Respiratory syncytial virus (RSV)**:  Abrysvo |

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| Assess the patient | | | | | | | | | | | | |
| Check the patient is suitable for vaccination: | | | | | | | | | | | | |
| Is the patient eligible for the vaccine?\* | Yes | | | | | | | | | No | | |
| If you selected **Yes**, select the first relevant eligibility type: | | | | | | | | | | | | |
| Eligibility type\* | Residents in care homes  Staff working in care homes  Healthcare workers  Social care workers  Age-based eligibility  Pregnancy  People with immunosuppression  People in other clinical risk groups  People who are homeless or live in closed settings like supported living accommodation  Household contacts of people with immunosuppression  Carer  People that have had CAR-T therapy or stem cell transplantation since receiving their last vaccination | | | | | | | | | | | |
| If you selected **Pregnancy** for Pertussis or RSV, enter the expected due date: | | | | | | | | | | | | |
| Expected due date\* |  |  | / |  |  | / |  |  |  |  |  | DD/MM/YYYY |
| If you selected **Healthcare workers**, select the staff role: | | | | | | | | | | | | |
| Staff role\* | Doctor  Qualified nurse/midwife  All other professionally qualified clinical staff  Clinical support  Non-clinical | | | | | | | | | | | |
| Assessment date\* |  |  | / |  |  | / |  |  |  | |  | DD/MM/YYYY |
| Legal mechanism\* | National protocol (NP)  Patient group direction (PGD)  Patient specific direction (PSD)  Written instruction (WI) | | | | | | | | | | | |
| Assessment outcome\* | Give vaccine | | | | | | | | | Vaccine not given | | |
| Comments (optional) |  | | | | | | | | | | | |
| If the **vaccine was not given**, give a reason: | | | | | | | | | | | | |
| Reason vaccine not given\* | Not appropriate to vaccinate today, patient advised to rebook  Patient declined  Vaccine contraindicated | | | | | | | | | | | |

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| Record consent | | | | | | | | | | | | | | | | | | |
| Does the patient or someone on their behalf consent to the vaccination?\* | Yes, they consent | | | | | | | | | No | | | | | | | | |
| If you selected **Yes**, **they consent**, confirm who gave consent: | | | | | | | | | | | | | | | | | | |
| Consent given by\* | Patient (informed consent)  Person with parental responsibility  Court appointed deputy  Independent mental capacity advocate  Clinician following the Mental Capacity Act (in the patient’s best interests)  Person with lasting power of attorney for personal welfare | | | | | | | | | | | | | | | | | |
| If someone gave consent on behalf of the patient, complete their details: | | | | | | | | | | | | | | | | | | |
| Name of the person consenting\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |
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| Relationship to the patient\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |
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| If **no** **consent was given**, confirm the reason: | | | | | | | | | | | | | | | | | | |
| No consent reason\* | Having elsewhere/had vaccination  Other  Personal choice  Porcine (pork) | | | | | | | | | | | | | | | | | |

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| Vaccinate | | | | | | | | | | | | |
| Have you vaccinated the patient?\* | Yes | | | | | | | | | | No | |
| Vaccination date\* |  |  | / |  |  | / |  |  |  |  | | DD/MM/YYY |
| Select where the vaccination is taking place | Hospital hub for staff and patients  Vaccination centre open to the public  Community pharmacy  Care home  Housebound patient's home  Off-site outreach event | | | | | | | | | | | |

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| If youselected **Care home,** enter the following information: | | | | | | | | | | | | | | | | | | | | | |
| Organisation name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Address\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Postcode\* |  |  |  |  |  |  |  |  |  | | | | | | | | | | | | |
| ODS Code\* |  |  |  |  |  |  | | | | | | | | | | | | | | | |

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| If the **vaccine was not given**, confirm the reason: | | | | | | | | | | | |
| No vaccination reason\* | Not appropriate to vaccinate today, patient advised to rebook  Patient declined  Vaccine contraindicated | | | | | | | | | | |
| If the **vaccine was given**, complete the details below: | | | | | | | | | | | |
| Vaccination site\* | Left upper arm  Right upper arm  Left buttock  Right buttock  Left thigh  Right thigh  Nasal  Oral | | | | | | | | | | |
| Batch number\* |  |  |  |  |  |  | - |  |  |  |  |
| Batch expiry date\* |  |  | / |  |  | / |  |  |  |  | DD/MM/YYYY |
| Dose amount (ml)\* |  |  |  |  |  | | | | | | |

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| Assessing and consenting clinician | | | | | | | | | | | | | | | | | |
| First name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Last name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Vaccinator | | | | | | | | | | | | | | | | | |
| Is the vaccinator the same person as the clinician named above?\* | Yes | | | | | | | | | No | | | | | | | |
| If you selected **No**, confirm the vaccinator's details: | | | | | | | | | | | | | | | | | |
| First name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Last name\* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |