



Record a vaccination service

Use this form if the service is temporarily unavailable.

Asterisk (*) indicates a mandatory field.

Patient's details	
First name*	
Last name*	
NHS number	
Date of birth*	DD/MM/YYYY
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Telephone	
Address*	
Postcode	

Your organisation's details	
Name*	
Delivery team or site*	

Choose vaccine*
COVID-19: <input type="checkbox"/> Comirnaty 30 JN.1 <input type="checkbox"/> Comirnaty 10 JN.1 <input type="checkbox"/> Comirnaty 3 JN.1 <input type="checkbox"/> Spikevax JN.1
Flu: <input type="checkbox"/> Adjuvanted Trivalent Influenza Vaccine (aTIV) <input type="checkbox"/> Cell-based Trivalent Influenza Vaccine (TIVc) <input type="checkbox"/> Eflueda (TIV-HD) <input type="checkbox"/> Fluenz (LAIV)



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<input type="checkbox"/> Influvac (TIVe) <input type="checkbox"/> Supemtek (TIVr) <input type="checkbox"/> Vaxigrip (TIVe)
Pertussis: <input type="checkbox"/> Adacel vaccine suspension <input type="checkbox"/> Boostrix-IPV suspension <input type="checkbox"/> Repevax vaccine suspension
Respiratory syncytial virus (RSV): <input type="checkbox"/> Abrysvo

Assess the patient	
Check the patient is suitable for vaccination:	
Is the patient eligible for the vaccine?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you selected Yes , select the first relevant eligibility type:	
Eligibility type*	<input type="checkbox"/> Residents in care homes <input type="checkbox"/> Healthcare workers <input type="checkbox"/> Social care workers <input type="checkbox"/> Age-based eligibility <input type="checkbox"/> Pregnancy <input type="checkbox"/> Household contacts of people with immunosuppression <input type="checkbox"/> Carer <input type="checkbox"/> In a clinical risk group
If you selected Pregnancy for Pertussis or RSV, enter the expected due date:	
Expected due date*	<input type="text"/> / <input type="text"/> / <input type="text"/> DD/MM/YYYY
If you selected Healthcare workers , select the staff role:	
Staff role*	<input type="checkbox"/> Doctor <input type="checkbox"/> Qualified nurse/midwife <input type="checkbox"/> All other professionally qualified clinical staff <input type="checkbox"/> Clinical support <input type="checkbox"/> Non-clinical
Assessment date*	<input type="text"/> / <input type="text"/> / <input type="text"/> DD/MM/YYYY
Legal mechanism*	<input type="checkbox"/> National protocol (NP) <input type="checkbox"/> Patient group direction (PGD)

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	<input type="checkbox"/> Patient specific direction (PSD) <input type="checkbox"/> Written instruction (WI)	
Assessment outcome*	<input type="checkbox"/> Give vaccine	<input type="checkbox"/> Vaccine not given
Comments (optional)		
If the vaccine was not given , give a reason:		
Reason vaccine not given*	<input type="checkbox"/> Not appropriate to vaccinate today, patient advised to rebook <input type="checkbox"/> Patient declined <input type="checkbox"/> Vaccine contraindicated	

Record consent																
Does the patient or someone on their behalf consent to the vaccination?*	<input type="checkbox"/> Yes, they consent								<input type="checkbox"/> No							
If you selected Yes, they consent , confirm who gave consent:																
Consent given by*	<input type="checkbox"/> Patient (informed consent) <input type="checkbox"/> Person with parental responsibility <input type="checkbox"/> Court appointed deputy <input type="checkbox"/> Independent mental capacity advocate <input type="checkbox"/> Clinician following the Mental Capacity Act (in the patient's best interests) <input type="checkbox"/> 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*																
Relationship to the patient*																
If no consent was given , confirm the reason:																
No consent reason*	<input type="checkbox"/> Having elsewhere/had vaccination															



If the vaccine was not given , confirm the reason:	
No vaccination reason*	<input type="checkbox"/> Not appropriate to vaccinate today, patient advised to rebook <input type="checkbox"/> Patient declined <input type="checkbox"/> Vaccine contraindicated
If the vaccine was given , complete the details below:	
Vaccination site*	<input type="checkbox"/> Left upper arm <input type="checkbox"/> Right upper arm <input type="checkbox"/> Left buttock



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	<input type="checkbox"/> Right buttock <input type="checkbox"/> Left thigh <input type="checkbox"/> Right thigh <input type="checkbox"/> Nasal <input type="checkbox"/> Oral											
Batch number*												
Batch expiry date*			/			/						DD/MM/YYYY
Dose amount (ml)*												

Assessing and consenting clinician																	
First name*																	
Last name*																	
Vaccinator																	
Is the vaccinator the same person as the clinician named above?*	<input type="checkbox"/> Yes								<input type="checkbox"/> No								
If you selected No , confirm the vaccinator's details:																	
First name*																	
Last name*																	