Classification: Official

Rural West PCN COVID-19 Vaccination Record form v.7a

Please fill form in **BLOCK** capitals * indicates section is **mandatory** and must be completed

Patient's details

FIRST NAME*	
SURNAME*	
Address	
NHS Number	**Postcode**
DATE OF BIRTH*	Sex: ☐ Male ☐ Female ☐ Not Stated

Clinical Screening

Exclusion Checklist*	1. Has the individual experienced major venous and/or arterial thrombosis occurring with thrombocytopenia following vaccination with any COVID-19 vaccine	☐ Yes	☐ No
	2. Is the individual currently unwell with fever?	☐ Yes	☐ No
	3. Has the individual ever had any serious allergic reaction to any ingredients of the Covid-19 vaccines, drug or other vaccine?	☐ Yes	☐ No
	4. Has the individual ever had an unexplained anaphylaxis reaction?	☐ Yes	☐ No
	5. Does the individual have a history of heparin-induced thrombocytopenia and thrombosis (HITT or HIT type 2)?	☐ Yes	☐ No
	6. Does the individual have a history of capillary leak syndrome?	☐ Yes	☐ No
Caution Checklist*	7. Has the individual had any vaccination in the last 7 days?	☐ Yes	☐ No
	8. Has the individual indicated they are, or could be pregnant?	☐ Yes	☐ No
	9. Has the individual informed you they are currently or have been in a trial of a potential coronavirus vaccine?	☐ Yes	☐ No
	10. Is the individual taking anticoagulant medication, or do they have a bleeding disorder?	☐ Yes	☐ No
	11. Does the individual currently have any symptoms of Covid -19 infection?	☐ Yes	☐ No
	12. Has the individual experienced an urticarial (itchy) skin reaction following their first / second COVID-19 vaccine dose?		☐ No
	13. Are you severely immunocompromised?	☐ Yes	☐ No

Consent

Consent*	Do you give consent to receive the vaccine?	☐ Yes	☐ No
Consent provided by*	☐ Patient ☐ Healthcare Lasting Power of Attorney ☐ Court Appointed Deputy ☐ Clinician using Best Interests process of Mental Capacity Act		

If consent was **not** obtained by the Patient, then please complete the below fields:

Individual Consulted	
Authorising Clinician	

Additional Information

Occupation	1. Are you a carer?	☐ Yes	☐ No
	2. Are you a social care worker?	☐ Yes	☐ No
	3. Are you a health care worker?	☐ Yes	☐ No
	4. Do you work in a residential care home for older people?	☐ Yes	☐ No
	5. Do you live in a residential care home?	☐ Yes	☐ No

Ethnic Category

What is your ethnic category?

White ☐ British ☐ Irish ☐ Other White

Mixed ☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Other Mixed

Asian or Asian British ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Other Asian

Black or Black British ☐ Caribbean ☐ African ☐ Other Black

Other Ethnic Groups ☐ Chinese ☐ Other ☐ Not Stated

Vaccination - OFFICIAL USE ONLY

Name/Initials Vaccinator		Notes
Date/Time of vaccination		
Site of administration	☐ Left deltoid ☐ Right deltoid	