

# Community Pharmacy IM Flu Vaccination Consultation Form Newcastle City Council 2013/14 (FCF – NCC)

## 1. Patient Details

Date of Consultation ...../...../.....  
Patient Date of Birth ...../...../.....  
GP Practice .....  
(Please include address) .....  
Ethnicity .....  
Directorate .....  
Staff ID number .....

Name
Address
Postcode
Cover with PMR Bag Label
Mobile No:

## 2. Referral Method

Patient Self Referral  Pharmacist  GP Surgery  Other

Did you receive a Flu vaccination last year? Yes  No  ----- If Yes, Was it in a pharmacy? Yes  No

## 3. Eligibility for NHS flu vaccine

Over 65 years of age  Pregnant  Respiratory Disease  Heart Disease  Liver Disease  Kidney Disease   
Neurological Disease  Diabetes Mellitus  Main Carer  Immunosuppressed  Long Stay Res./Nursing Home   
Not Eligible / Private Newcastle City Council occupational health vaccination

(Please note, risk group should be verified either by patient letter from GP/LASCA inviting the patient for flu vaccination Or where appropriate by reviewing PMR in discussion with the patient. Pregnancy can be verified by pregnancy notes or discussion with patient.) Occupational health vaccination should be verified by checking the staff ID badge.

Verified by: GP/LAT Letter  PMR  Staff ID badge  Other .....

## 5. Medical History

Is the patient aged under 18? Yes  No  (If yes refer patient to GP for Nasal Vaccination)

Is the patient well today? [minor colds and coughs are not exclusions] Yes  No

Any Medical Conditions \_\_\_\_\_

Current Medication \_\_\_\_\_

Allergies \_\_\_\_\_

Vaccine NOT GIVEN  To return another day  Referred to GP

## 5. To be completed by the Patient

- I confirm that I have not had a flu vaccine this year
- I have been informed and understand the benefits and possible side effects of the flu vaccine.
- I give permission to send a copy of this consultation form to Newcastle City Council and my GP to update my records
- I consent to receiving the flu vaccine.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## 6. Record of vaccine administered (to be completed by pharmacist)

Brand (peel off label) \_\_\_\_\_  
Batch No (peel off label) \_\_\_\_\_  
Expiry Date \_\_\_\_\_  
Injection site Left  / Right  Deltoid

Vaccine Label
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Pharmacy Name
Address
Postcode
Tel No.
Stamp can be used.

Pharmacist Name \_\_\_\_\_

Pharmacist Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Encourage Patient to complete survey before leaving pharmacy**

Please fax this completed consultation form to the patient's GP immediately after the consultation. Send list of vaccinated staff names to [occupational.health@newcastle.gov.uk](mailto:occupational.health@newcastle.gov.uk)

## 7. Record of vaccine administered (to be completed by GP practice)

Please use READ code 65E20 when updating the patient's details.