

# Community Pharmacy IM Flu Vaccination Consultation Form 2014/15

## 1. Patient Details

Date of Consultation ...../...../.....  
Patient Date of Birth ...../...../.....  
GP Practice .....  
(Please include address) .....  
Ethnicity .....

Name  
Address  
Postcode  
Cover with PMR Bag Label  
Mobile No:

## 2. Consent (To be completed by 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 NHS England and my GP to update my records
- I consent to receiving the flu vaccine.

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

## 3. Previous Vaccination

Did you receive a Flu vaccination last year? Yes  No  ----- If Yes, Where? GP  Pharmacy  Other

## 4. 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 Vaccination

(Please note, risk group should be verified or where appropriate by reviewing PMR in discussion with the patient.)

Verified by: GP/LAT Letter  PMR  Proof of Age  Proof of Carers Allowance  Contacted GP Practice   
Known Resident of Care Home  Other (Please State)  .....

## 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

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

Vaccine Label

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

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**

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

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