NHS

NHS Stockport NHS Foundation Trust

# Individual Patient assessment for the administration of Pfizer BioNTech COVID-19 mRNA Vaccine BNT 162b2

| | | | |
|---|---|---|---|
| **Name** | | **Date of birth** | **Age over 16 only** |
| **Surname** | | **NHS Number** | |
| **Date of 1st Vaccination** (If applicable) | | **Attendance Date** | |

**NHS Trust Staff ☐ NHS Other Staff ☐ NWAS ☐**

**Please ask the person presenting for vaccination these questions and record that they have received appropriate information as to the purpose of the vaccine and side effects**

| | | | | |
|---|---|---|---|---|
| Are you currently unwell with fever? ***[Contra-indication]*** | **No** | ☐ | **Yes** | ☐ |
| Have you ever had any serious reaction (anaphylaxis) to a vaccination that needed admission to hospital? ***[Contra-indication]*** | **No** | ☐ | **Yes** | ☐ |
| Have you received any vaccination within the past 7 days ***[Caution-see National protocol]*** | **No** | ☐ | **Yes** | ☐ |
| Do you have any allergies resulting in hospital admission or anaphylaxis to a vaccine, medicine or food, injected antibody preparation or a medicine likely to contain PEG (such as depot steroid injection, laxative) ***[Contra-indication]*** | **No** | ☐ | **Yes** | ☐ |
| Do you have a history of immediate anaphylaxis (major allergic reaction) to multiple, different drug classes, with the trigger unidentified (this may indicate polyethylene glycol (PEG) allergy ***[Contra-indication]*** | **No** | ☐ | **Yes** | ☐ |
| Have you ever had a major allergic reaction (anaphylaxis) of unknown cause? ***[Contra-indication]*** | **No** | ☐ | **Yes** | ☐ |
| Are you pregnant? ***[Caution-see National protocol]*** | **No** | ☐ | **Yes** | ☐ |
| Do you have any bleeding disorder or take anticoagulant medication? ***[Caution – If required Consult Pharmacist if on anticoagulant medication]*** | **No** | ☐ | **Yes** | ☐ |
| Have you had Covid or had a positive COVID test in the last 4 weeks? ***[Caution]*** | **No** | ☐ | **Yes** | ☐ |
| Are you or have you been in a trial of a potential coronavirus vaccine? – (They need to establish if they received the vaccine or placebo-refer back to Trial investigators) ***[Contra-indication]*** | **No** | ☐ | **Yes** | ☐ |
| Have you previously had a Covid vaccination? | **No** | ☐ | **Yes** | ☐ |
| If **YES** – did you have any reaction to the 1st dose of Covid vaccine? | **No** | ☐ | **Yes** | ☐ Complete Adverse reaction form & section overleaf |
| Was it within the preceeding 21 days? [Contra-indication] | **No** | ☐ | **Yes** | ☐ |
| Do you consent to vaccination? | **Yes** | ☐ | **No** | ☐ |
| Are you aware of the vaccine purpose and side effects? | **Yes** | ☐ | **No** | ☐ |

- **If any of the boxes in red are ticked, then a further review must take place.**

## Adverse Reactions / Not Vaccinated on this Occasion

| | | | |
|---|---|---|---|
| **Reaction Type:** *e.g. Anaphylaxis* | | **Reaction:** *e.g. Swollen Lips* | |
| **Criticality:** *e.g. Mild / severe* | | **Verification Status:** *e.g. verified by GP/ Dr?* | |
| **Date First Experienced:** | | | |
| **Comments:** | | | |
| **Not Vaccinated Reason** | Contraindicated ☐ Declined Course ☐ Declined Dose ☐ Unable to vaccinate ☐ | | |

## Covid Vaccination

| | | | |
|---|---|---|---|
| **Batch Number:** | | **Batch Expiry Date:** | |
| **Manufacturer Product Code:** | | **Unique Serial Number:** | |
| **Manufacturer:** | Pfizer | **Vaccine Type:** | COVID-19 mRNA Vaccine BNT162b2 |
| **Vaccination Site:** | Left Upper Arm ☐<br>Right Upper Arm ☐ | **Dose:** | 1st Dose ☐<br>2nd Dose ☐ |

| | | |
|---|---|---|
| **Date:** ...........................<br>**Time:** ...........................<br>**Injection Site:** ...................................................... | **Vaccinator Details:**<br>.........................................<br>**PRINT NAME**<br>.........................................<br>**SIGNATURE** | **ID**<br>(ie NMC No.) |

**Please tick as appropriate**

**Inputted onto NIVs** **Yes** ☐ **No** ☐