COVID-19 Pfizer Vaccine Consent Form

NHS
Liverpool Heart and Chest Hospital
NHS Foundation Trust

Section 1: Personal Details *(to be completed by vaccinee)*

First name

Surname

Date of birth ☐☐ – ☐☐ – ☐☐☐☐ Age ☐☐☐

Gender Male ☐ Female ☐ Prefer not to say ☐

Home address

Postcode ☐☐☐☐☐☐☐

NHS number ☐☐☐ – ☐☐☐ – ☐☐☐☐

Tel number

Email address

GP name

GP practice

☐ LHCH Trust employee ☐ Other NHS employee ☐ Social care employee

☐ Care home employee ☐ Local authority employee ☐ LHCH staff relative

☐ LHCH inpatient ☐ LHCH outpatient ☐ Primary care patient

☐ Care home patient ☐ Paid carer ☐ Unpaid carer

Section 2: Consent *(to be completed by vaccinee)*

Please confirm the following statements by placing a tick in the box:

1. I confirm I have received and read the COVID-19 vaccine information leaflet. ☐ (tick)

2. I confirm I understand the risks and benefits of the COVID-19 vaccine being offered. ☐ (tick)

3. I understand that I must rebook and attend for the second dose of the vaccine as scheduled. ☐ (tick)

4. I consent to receiving the 1st and 2nd dose of the COVID-19 vaccine. ☐ (tick)

Signature Date ☐☐ – ☐☐ – ☐☐☐☐

If you are completing this form on behalf of the individual in their best interest, please state:

Name

Relationship

Date of Birth ☐☐ – ☐☐ – ☐☐☐☐

Section 3: Pre-screening Assessment for Pfizer Vaccine Only *(to be completed by vaccinee)*

Please note: Exclusion does not necessarily mean the vaccine is contraindicated but would be outside protocol.
Email vaccine@lhch.nhs.uk to discuss alternative assessment

Are you feeling unwell today?	No	☐	Yes	☐	exclude: do not give
Do you have any COVID-19 symptoms? *(i.e. high temperature, a new continuous cough, a loss or change with your sense of smell or taste)*	No	☐	Yes	☐	exclude: advise to self isolate
Do you have a history of allergic reactions to any of the Covid vaccine ingredients or anaphylaxis after 1st dose?	No	☐	Yes	☐	exclude: do not give
Do you have a history of immediate onset anaphylaxis to multiple classes of drugs or unexplained anaphylaxis?	No	☐	Yes	☐	exclude: do not give
Are you or could you be pregnant?	No	☐	Yes	☐	exclude: do not give
Are you breastfeeding?	No	☐	Yes	☐	read current Gov information
Have you had a previous dose of the COVID-19 vaccine?	No	☐	Yes	☐	do not give within 21-days of 1st dose or 12-weeks after 1st dose unless authorised by clinical supervisor
If yes, what was the date?	☐☐–☐☐–☐☐☐☐				
What was the brand?	Pfizer mRNA vaccine BNT162b2	No	☐	Yes	☐ do not give if not Pfizer
If not Pfizer please specify					
Have you already completed a course of COVID-19 vaccination?	No	☐	Yes	☐	exclude: do not give
Have you participated in a COVID-19 vaccine clinical trial?	No	☐	Yes	☐	confirm not had active drug
Have you had confirmed COVID-19 infection in last 4-weeks?	No	☐	Yes	☐	exclude: do not give
Have you received any other vaccine in the last 7-days?	No	☐	Yes	☐	exclude: do not give
Are you immunosuppressed or taking immunosuppressants?	No	☐	Yes	☐	counsel for reduced response
Are you about to commence immunosuppressant therapy?	No	☐	Yes	☐	vaccinator to discuss 2nd dose interval
Are you taking anticoagulants? (Ensure INR not above range)	No	☐	Yes	☐	apply pressure for 2-mins
Do you have a disorder that makes you prone to bleeding?	No	☐	Yes	☐	apply pressure for 2-mins
Are you under 16-years of age?	No	☐	Yes	☐	exclude: do not give
Have you had a previous non-anaphylactic reaction to a COVID-19 vaccine?	No	☐	Yes	☐	vaccinator to discuss with clinical supervisor
Do you have a BMI over 40?	No	☐	Yes	☐	use longer needle

If you have answered yes to any of the above please provide further details:

Name:

Date of birth: ☐☐–☐☐–☐☐☐☐

Section 4: Eligibility and Administration Record *(to be completed by vaccinator if no access to online NIMS database)*

I have confirmed the individual's personal details as per section 1? Yes ☐

Does the individual meet any exclusion criteria? No ☐ Yes ☐ exclude: do not give

Has the individual had the opportunity to ask any questions? No ☐ Yes ☐

Has the individual provided signed consent in section 2? No ☐ Yes ☐

Are any additional precautions or advice required? (e.g. bleeding risk)? No ☐ Yes ☐

If yes please provide details:

Vaccination site: Right deltoid ☐ Left deltoid ☐ Other ☐ (note this is off-label)

If other, state site and rationale:

Is this the 1st / 2nd dose?: 1st dose ☐ 2nd dose ☐

Batch number:

Time of administration: ☐☐ — ☐☐

Size of needle used?: Standard (23G x 25mm) ☐ Longer (23G x 38mm) ☐

Please provide details of any advice given on discharge about adverse effects:

Advised on 15-min post vaccine wait time? Yes ☐

Vaccinator first name:

Vaccinator surname:

Profession: Doctor ☐ Nurse / Midwife ☐ Nursing Associate ☐ Pharmacist ☐

Operating department practitioner ☐ Physiotherapist ☐ Paramedic ☐

Other, please state:

Section 5: Adverse Drug Reaction *(to be completed by vaccinator)*

Did a reaction occur? No ☐ Yes ☐

If yes, please give details:

If yes, please complete yellow card report via MHRA (http://coronavirus-yellowcard.mhra.gov.uk)