COVID-19 Pfizer 3rd Dose Vaccine for Immunosuppressed Patients

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 have received and understand information explaining why I need a 3rd dose of COVID-19 vaccine ☐ (tick)

2. I confirm I understand the risks and benefits of the COVID-19 vaccine being offered. ☐ (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
Previous systemic allergic reaction (including immediate onset anaphylaxsis) to a previous dose of a COVID-19 mRNA vaccine or to any component of the vaccine or residues from the manufacturing process?	No	☐	Yes	☐	exclude: refer to allergist
Have a history of immediate anaphylaxsis to multiple, different drug classes, with the trigger unidentified (this may indicate polyethylene glycol 'PEG' allergy)?	No	☐	Yes	☐	exclude: refer to allergist
Have a history of anaphylaxsis to a vaccine, injected antibody preparation or a medicine likely to contain PEG (such as depot steroid injection, laxative)?	No	☐	Yes	☐	exclude: refer to allergist
Have a history of idiopathic anaphylaxsis?	No	☐	Yes	☐	exclude: refer to allergist
Have you had both 1st and 2nd dose of the COVID-19 vaccine?	No	☐	Yes	☐	refer to supervisor
Date of 2nd dose?	☐☐–☐☐–☐☐☐☐				
I received my 2nd COVID-19 vaccine at least 8-weeks ago	No	☐	Yes	☐	exclude: do not give
Have you participated in a COVID-19 vaccine clinical trial?	No	☐	Yes	☐	refer to investigator, written consent required
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 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
Do you have a BMI over 40?	No	☐	Yes	☐	use longer needle
Are you or could you be pregnant? If YES, risk/benefit as per RCOG	No	☐	Yes	☐	see clinical supervisor
Are you breastfeeding?	No	☐	Yes	☐	read current Gov information

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)