Private RAF: Influenza I Meningitis ACWY I Meningitis B I Hepatitis B I Pneumococcal Date: _ _ / _ _ / 2 0 1 _

Patient's personal details	
Title: Mr: ☐ Miss: ☐ Ms: ☐ Mrs: ☐ Dr: ☐	Patient Address:
First Name:	NHS No. (if known):
Last Name:	GP Name and Address:
Telephone:	GP Telephone (if known):
Gender: Male: ☐ Female: ☐ D.O.B: ___ ___/ ___ ___ / ___ ___ ___ ___ Age:	Would you like us to send a copy of this consultation to your GP? ☐

Patient's personal details			
Tick which of the following applies to you…	***Yes***	***No***	***Add extra details if required.***
Are you feeling well today? (If not, please provide details, e.g. you have a temperature or an infection)			
Do you take any regular medicines? If yes, state name & dose…			
Have you had a flu vaccine in the past 6 months?			
Have you had a BCG/tuberculosis injection in the past 3 months?			
Have you had a live vaccine (MMR, shingles, YF…) in the last month?			
Are you allergic to egg, latex, neomycin, gelatine, streptomycin or polymyxin B or any other vaccines or excipients?			
Have you ever had a confirmed anaphylaxis reaction?			
Do you have any of the following? (please tick as appropriate): Evolving neurological disease (cerebal palsy, MS…) ☐ | HIV infection, splenectomy, or taking long-term immunosuppressives or chemotherapy ☐ Bleeding disorders, or take an anti coagulant ☐ | Pregnancy ☐			
Write below any further information which may be relevant e.g. medicines taking, conditions suffered, concerns...			

For the Supply of Vaccination:						
Date	Formulation	Batch No. & Expiry	Administration site	Comment	Time	Signature

Additional Vaccination Advice:

CUSTOMER IS ADVISED TO WAIT 15 MINUTES POST VACCINATION.

Immunisation against the virus usually causes no problems. You may have a temporary mild soreness at the injection sight and possible muscle aches for a day or so. This soon settles and does not lead to other problems. Serious reactions very rarely occur.

PATIENT CONSENT

I have received information on the risks and benefits of the medicines recommended and fully understand them. I have also had the opportunity to ask questions. I consent to the recommended medicines being given at each appointment*.

Patient or Guardian Name / signature ...../ ...../ ..... **Date**.....

Do you consent for our pharmacy and/or our authorising medical agency to contact you regarding customer satisfaction? Yes / No

PHARMACIST AGREEMENT

I have consulted the specific PGD which enables me to supply the listed medicine and have found that the patient is included in treatment and there are no valid exclusions applicable. I have given the patient information on the risks and benefits of the medicines recommended and have done my utmost to ensure the patient fully understands them. I have also given the patient the opportunity to ask questions. This will be carried out at each appointment.

Pharmacist Name / signature ...../ ...../ ..... **Date**.....