pharmadoctor

Influenza vaccine
Offline risk assessment form

Patient details

First name:	**Last name:**
Email:	**Telephone:**
Date of birth: _ _ / _ _ / _ _ _ _	**Age:** _____
Home Address:	**Name & Address of GP** Would you like your GP to be informed of this consultation? Yes ☐ No ☐

Please answer the following questions

Have you had a high fever or temperature in the last 24 hours? Yes ☐ No ☐	Are you breast-feeding? Yes ☐ No ☐
Have you ever had an allergic or anaphylactic reaction to a vaccine before? Yes ☐ No ☐ *If yes, please provide details*	Do you have any allergies? Yes ☐ No ☐ *If yes, please provide details*
Are you pregnant, or is there any possibility that you could be pregnant? Yes ☐ No ☐	Do you have a bleeding disorder, including taking any medication that thins your blood (anticoagulants)? Yes ☐ No ☐
Are you currently taking any medication (over the counter or prescription)? Yes ☐ No ☐ *If yes, please provide details*	Have you already had a flu vaccine for this flu season? Yes ☐ No ☐

Please tick if any of the below clinical risk groups apply:

Chronic respiratory disease	☐	Chronic liver disease	☐
Chronic heart disease	☐	Diabetes	☐
Chronic renal disease	☐	BMI 40 or above	☐
Chronic neurological disease (excluding stroke/transient ischaemic attack)	☐	Immunosuppression	☐
Asplenia or dysfunction of the spleen	☐		

NHS eligibility, please tick if any of the following apply:

Carer	☐	Social care worker	☐
Hospice worker	☐	In a long-stay residential home	☐
Close contact of an immunocompromised person	☐		

Patient consent

1. I have received information on the risks and benefits of the medicine, and I have had the opportunity to ask questions. The medical information I have provided is true and accurate to the best of my knowledge, and I consent to the medicine being administered.
2. I understand that my personal information, including name, surname, email, telephone, date of birth (DOB), address, NHS number, and GP details, will be securely uploaded to the Pharmadoctor website for electronic storage, and it will be kept in line with data protection regulations along with the details of the consultation (i.e., medicines provided).
3. I authorise the collection, storage, and secure transmission of my information for the purposes mentioned above.
4. I acknowledge that after the consultation, the details of my medication and consultations will be accessible through my Pharmadoctor account, using the provided email address for login.
5. I understand that I can speak to a member of staff about any queries regarding the Pharmadoctor consultation or the processing of personal data for this consultation, including exercising my rights under data protection legislation.

Patient signature:	**Date:**

Supply record (healthcare professional use)

Medicine name	Date provided	Administration method	Quantity	Strength	Batch number	Drug expiry date	Price

How to use this form (healthcare professional use)

Consultations should be completed in your Pharmadoctor account using the eTool consultation platform. However, if you do not have access to your Pharmadoctor account at the time of the consultation, this form may be used to record the consultation details. Please upload the details to the eTool at a later time when you have access to your Pharmadoctor account.