## Welsh Immunisation System paper back up

This form is for use by staff involved in administration of COVID-19 vaccination. All data requested on the form must be completed. This form should not be used as a main record but is available to support the recording of data on the Welsh Immunisation System (WIS). Data recorded on this form should be entered into WIS as soon as this is possible.

**Please inform patient:** Your personal information and any immunisation you have will be recorded and shared within the NHS for the purpose of record-keeping and vaccine-monitoring. If they wish to find out how the NHS uses their information, signpost to: <a href="https://l11.wales.nhs.uk/AboutUs/yourinformation/">https://l11.wales.nhs.uk/AboutUs/yourinformation/</a>

## PLEASE USE BLOCK CAPITALS

Date attended  Surname  Sex (not mandatory to ask)  Ethnic group*  Address  Postcode  Eligibility Group*  Email address  Immunisation location name  Immunisation location address  Preferred contact language  Time attended  First name  Date of birth (DD/MM/YYYY)  Care home resident  Yes  Telephone number  Mobile number  GP Practice  GP Practice  GP Practice  Letter Telephone contact method	No
Sex (not mandatory to ask)  Rhown  M F Not specified  Care home resident  Yes  Address  Postcode  Eligibility Group*  Email address  Immunisation location name  Immunisation location address  Preferred contact  English  Not specified  Postcode  Telephone number  Mobile number  GP Practice  GP Practice  GP Preferred  Letter  Telephone  Letter	No
Sex (not mandatory to ask)   known   Manual Specified   Specified   Care home resident   Yes	No
Ethnic group*  Address  Postcode  Eligibility Group*  Email address  Mobile number  Immunisation location name  Immunisation location address  Preferred contact  English  Welsh  Preferred  Care home resident  Yes  Address  Free home resident  Yes  Free home resident  Yes  Free home resident  Yes  Free home resident  Yes  Free home resident  Fre	No
Address  Postcode  Eligibility Group*  Email address  Mobile number  Immunisation   GP Practice   Indication address  Indication address  Preferred contact  English  Welsh  Preferred  Letter Teleph	1
Eligibility Group*  Telephone number  Email address  Mobile number  Immunisation location name  Immunisation location address  Preferred contact  English  Welsh  Preferred  Letter  Telephone number  GP Practice  Letter  Telephone number  Letter  Freferred  Letter  Telephone number  Letter  Letter  Telephone num	
Eligibility Group*  Email address  Mobile number  Immunisation location name Immunisation location address  Preferred contact  English  Welsh  Telephone number  GP Practice  GP Practice  Letter  Telephone number  Letter  Telep	
Email address  Mobile number  Immunisation location name  Immunisation location address  Preferred contact  English  Mobile number  GP Practice	
Email address  Mobile number  Immunisation location name  Immunisation location address  Preferred contact  English  Mobile number  GP Practice	
Immunisation   GP Practice   Immunisation   Immunis	
Immunisation location name Immunisation location address Preferred contact English Welsh Preferred Letter Teleph	
location name Immunisation location address Preferred contact English Welsh Preferred Letter Teleph	
Immunisation location address  Preferred contact English Welsh Preferred Letter Teleph	
location address  Preferred contact  English  Welsh  Preferred  Letter  Teleph	
Preferred contact English Welsh Preferred Letter Teleph	
8 -	<u> </u>
language   Contact method	one Text
Employment details*	
(health and social care workers)	
Patient facing (circle one) Sector	
Employing Main location	
organisation of work (local	
Job role authority)  Ves  Ves	No
Sob forc	140
Patient assessment	
Do you give consent? Yes	No
Do you have any allergies?	No
Have you ever had an anaphylaxis to any medicine or vaccine or food or that  Yes	No
was unexplained?	
Have you received any vaccine in the last 7 days?	No
Are you pregnant? Yes	No
Is there any contraindication to or reason to postpone vaccination today?	No
Eligibility notes (other relevant details):	

<sup>\*</sup>see paper consent form reference list

		Vacci	nation deta	nils			
Date and time	1.Vaccine and product name 2. Diluent manufacturer*	Batch number 1.Vaccine 2. Diluent*	Expiry date	Site of injection	Route of administration	Dose (please	e tick)
						1st	2nd

<sup>\*</sup>Only necessary for Pfizer COVID-19 vaccine

Name of immuniser (please PRINT legibly)	Signature of immuniser

Adverse reaction record								
Adverse reaction	Yes	No	Type of adverse reaction	Local reaction only				
(please circle)			(please tick)	Syncope (faint)				
				Allergic reaction (but not				
				anaphylactoid)				
				Anaphylactoid reaction				
				Full anaphylaxis				