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| **Appointment Preparation** *(to be completed by staff)* |
| **Client name:** |  | **D.O.B** |  | **CIRTS** |  |
| **Authorised Decision Maker** N/A [ ]  |  | **Ph:**  |  |
| **Concerns to discuss at the appointment** *(client & staff to populate concerns prior to appointment)*  |
| Any of the following health conditions and how they may impact receiving the COVID-19 Vaccine |
| [ ]  | Allergies – severe reactions | [ ]  | Use of an EpiPen |
| [ ]  | Already had COVID-19 | [ ]  | Bleeding disorder  |
| [ ]  | Take medicines to thin blood | [ ]  | Have a weakened immune system |
| [ ]  | Recently been sick with sore throat, cough, or feeling sick in any way | [ ]  | Recently received another vaccination e.g. Whooping Cough, Tetanus |
| Other health concerns: |  |
|  |
|  |
|  |
| **Health Professional Direction** *(to be completed by Health Professional)*  |
| This person [ ]  has capacity [ ]  lacks capacity to make a decision about being vaccinated. |
| This person is Suitable [ ]  Unsuitable [ ]  to receive the COVID-19 Vaccination. |
| If not suitable, please provide details: |  |
|  |
|  |
|  |
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| **Treating Health Professional Details**  *(to be completed by Health Professional)*  |
| Name:  |  | Profession: |  |
| Signature |  | Date: |  |

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| **LWB Staff responsible for supporting client to attend appointment** *(completed by staff)* |
| Staff name:  |  | Staff Signature: |  |

**Upload to CIRTS as follows**: Health Tab> Add New Appointment Record > enter details >Add New Attachment>COVID-19 Vaccine Review SURNAME, First Name. YYYY.MM.DD