pharmadoctor

# HPV vaccine
# Risk Assessment Form

| | | |
|---|---|---|
| **Title:** Mr: ☐ Miss: ☐ Ms: ☐ Mrs: ☐ Other: ☐ | **D.o.B.:** _ _ / _ _ / _ _ | **Age:** _____ |
| **Name:** | **Home Address:** | |
| **Surname:** | | |
| **Email:** | **Name & Address of GP** (optional) | |
| **Telephone:** | **Would you like your GP to be informed of this consultation?** Yes ☐ No ☐ | |

**Please answer the following questions (must be completed by parent or guardian if under 16)**

| | | | |
|---|---|---|---|
| Do you feel unwell, have a temperature or an infection? | Yes ☐ No ☐ | Are you aware that the HPV vaccine does not treat infections/diseases that already exist because of HPV? | Yes ☐ No ☐ |
| Have you ever had an allergic or anaphylactic reaction to a HPV vaccine or any other vaccine before? *If yes please describe the reaction* | Yes ☐ No ☐ | Are you aware that Gardasil does not protect you from all HPV infections/diseases? | Yes ☐ No ☐ |
| Do you have any severe allergies? *If yes, please describe the allergy/reaction* | Yes ☐ No ☐ | Are you aware that the HPV vaccine is not a substitute for routine cervical screening? | Yes ☐ No ☐ |
| Are you immunosuppressed due to disease or treatment (e.g., HIV)? *If yes, please provide details* | | Have you received immunoglobulin or blood-derived products in the last 6 months? *If yes, please provide dates* | Yes ☐ No ☐ |
| Are you breast feeding? | Yes ☐ No ☐ | Applicable to female patients only: Are you pregnant, or is there any possibility that you could be pregnant? | Yes ☐ No ☐ |
| Do you feel any stress related reactions (e.g. feeling faint) when receiving a vaccine? *If yes please provide details* | Yes ☐ No ☐ | Are you aware that precautions against sexually transmitted disease should always be continued? | Yes ☐ No ☐ |
| Do you have a bleeding disorder, including taking any medication that thins your blood (anticoagulants)? | Yes ☐ No ☐ | Are you aware that the vaccine may not fully protect everyone who receives it? | Yes ☐ No ☐ |

**Please list all your current prescription medication including any medication you buy over the counter**

**Please provide details of any recent or past medical history of note (e.g. conditions you have previously been treated for)**

**PATIENT CONSENT**

I have received information on the risks and benefits of the vaccine 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 vaccine being given.

**Signature of patient, parent or guardian** _____ **Date** _____

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| HEALTHCARE PROFESSIONAL USE ONLY | |
|---|---|
| **Non-supply/administration** | |
| **I confirm that the patient did NOT receive the medication** ☐ | **Patient referred to GP** ☐ |
| **Reason for non-supply/administration** | |

| HEALTHCARE PROFESSIONAL USE ONLY | | | | |
|---|---|---|---|---|
| **Supply/administration** | | | | |
| Vaccine brand, batch number and expiry date | *Affix vaccine label here or write details* | L deltoid ☐<br>R deltoid ☐ | Date | Cost |
| | | | | |
| **I confirm that the patient is not contraindicated based on the information provided by the PGD** ☐ | | | | |
| **I have explained the potential warnings and side effects of the treatment to the patient, and requested they report them if they occur** ☐ | | | | |
| **I have provided the patient with an information leaflet (PIL) for the treatment I am administering, and advised them to read it** ☐ | | | | |
| **Healthcare Professional Name** | **Signature** | | | |