pharmadoctor

Meningococcal Group B vaccine Risk Assessment Form

Title: Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ 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)

Have you ever had an allergic or anaphylactic reaction to a meningitis B vaccine or any other vaccine before? *If yes, please describe the reaction* Yes ☐ No ☐	Do you have any allergies (e.g. latex)? *If yes, please describe the allergy/reaction* Yes ☐ No ☐
Are you immunosuppressed due to disease or treatment? *If yes, please provide details* Yes ☐ No ☐	Do you feel any stress related reactions (e.g. feeling faint) when receiving a vaccine? *If yes, please provide details* Yes ☐ No ☐
Do you have a bleeding disorder, are you taking any medication that thins your blood (anticoagulants) or do you bruise easily? Yes ☐ No ☐	Are you pregnant, planning pregnancy, or is there any possibility that you could be pregnant? *If yes, please provide details* Yes ☐ No ☐
Are you currently breast-feeding? Yes ☐ No ☐	Do you feel unwell, have a temperature or an infection? *If yes, please provide details* Yes ☐ No ☐

Please provide dates of previous meningitis B vaccines if known

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., personal or family history of seizures/convulsions)

Please list all vaccines that you have received in the last 4 weeks, and provide dates if known

Shingles	☐	Date:	Yellow Fever	☐	Date:	Oral typhoid	☐	Date:
Chicken Pox	☐	Date:	Influenza	☐	Date:	MMR	☐	Date:
Others (please name)	☐							

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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	__/__/____

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 ☐ R deltoid ☐ Anterolateral thigh ☐	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**		