**Patient Specific Direction (PSD) Flu Vaccination for Adult Influenza Vaccines**

**Section 1& 2:** To be completed by Prescriber in GP Surgery

**Section 3:** Patients to be identified by GP practice, assessed by practice prescriber and

 administration completed by trained DCHS Staff and list returned to Practice to update

 patient medical records and to store list for 2 years

|  |  |
| --- | --- |
| **Section 1**: | **Practice and Vaccine Details** |
| **Name of GP Practice:** |  |
| **Address:** |  | **Tel:** |
| **Brand Name of vaccination:** |  |
| **Dose:** | 0.5ml |
| **Route:** | Administer by intramuscular (I.M.) injection (unless the person has a bleeding disorder, e.g. thrombocytopenia or anticoagulant medication when the vaccine should be administered by deep subcutaneous (S.C.) injection. |
| **Expiry date of this PSD** ie date by which Flu vaccine should be administered  eg 31/12 / 2020  | \_ \_/\_ \_ /\_ \_ \_ \_ |

|  |  |
| --- | --- |
| **Section 2** | **GP or Practice Non-Medical Prescriber** |
| * I have reviewed and individually assessed each of the patients overleaf for appropriateness to receive the ‘flu’ vaccine named above including considering egg and latex allergy.
* I authorise the administration of the ‘flu’ vaccine to the patients named overleaf to be administered appropriately trained DCHS staff.

(The list over leaf maybe prepared by a member of the practice team. It is the GP’s/Practice NMP’s responsibility to review each patient on the list and determine if the vaccination is appropriate to be administered, considering if the flu vaccine has already been given in this current flu season, allergies, whether the patient has a bleeding disorder/ on therapeutic anticoagulation and so requires a S.C. injection AND to make clear adjustments to the list eg either by striking through the name with a single line so that it is clear that the vaccination is not to be given or endorsing S.C. route)* I confirm that this list is attached to the form.
 |
| GP / NMP Signed: |  | Print Name: |
| GMC No. or NMC Reg: |  | Date \_ \_/\_ \_ /\_ \_ \_ \_ |

|  |
| --- |
| **DCHS Community Nursing Team Responsibilities** |
| * An appropriately trained member of DCHS healthcare team may administer vaccines to patients in the community under a signed and current Patient Specific Direction (PSD) providing they:
* Have completed core vaccine training and the annual flu update training and is satisfied they are competent in all aspects of ‘flu’ vaccination
* Have familiarised themselves with the Brand of vaccine provided, including appropriate knowledge of the inclusion/exclusion criteria, contra-indications; warnings etc.
* Have completed training in recognition & treatment of anaphylaxis including life support, in the last year
* Are competent with administering IM and SC injections
* Understands and complies with administration in line with the Medicines Code including the 6 rights of Medicine Administration
 |
| * Complete the form overleaf and return it to GP practice for 2 years for safe keeping
 |
| * Check with the patient if they have already received the ‘Flu vaccine this season, if so, don’t proceed & inform GP practice.
 |

**Name and Dose of Flu Vaccine to be Administered:** …………………………………………… Dose 0.5ml

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Patient** | **Patient’s Address & Phone No.** | **Date of Birth** | **NHS No** | **Consent****🗸** | **Allergy check Y/N including eggs and latex**  | **Batch No.** | **Expiry Date** | **Injection Site** | **Route IM or SC** | **Date Given** | **Person Administering** |
| **Print Name** | **Signature** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |

**Name and Dose of Flu Vaccine to be Administered:** …………………………………………… Dose 0.5ml

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Patient** | **Patient’s Address & Phone No.** | **Date of Birth** | **NHS No** | **Consent****🗸** | **Allergy Y/N including eggs and latex** | **Batch No.** | **Expiry Date** | **Injection Site** | **Route IM or SC** | **Date Given** | **Person Administering** |
| **Print Name** | **Signature** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |

** Name and Dose of Flu Vaccine to be Administered:** …………………………………………… Dose 0.5ml

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Patient** | **Patient’s Address & Phone No.** | **Date of Birth** | **NHS No** | **Consent****🗸** | **Allergy Y/N including eggs and latex** | **Batch No.** | **Expiry Date** | **Injection Site** | **Route IM or SC** | **Date Given** | **Person Administering** |
| **Print Name** | **Signature** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |