|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Treating Health Professional Details**  *(to be completed by Health Professional)* | | | | | | | | | | | | | | | |
| Name: | |  | | | | Profession: | | | |  | | | | | |
| Signature | |  | | | | Date: | | | |  | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **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