

**Uimhir Aitheantais Cliant:** □□□□□□□□□□□□

<b>Ainm an tIonad Vacsaínithe:</b>	<b>Limistéar OSA :</b>
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- Léigh an t-eolas iniata maidir leis an H1N1 (Fliú na Muc)
- Freagair na ceisteanna le d' thoil agus sínigh an fhoirm toilithe thíos (peann dubh gus bloclitreacha)
- Tuismitheoirí agus caomhnóirí: Tá cead ag micléinn 16 agus os a chionn a fhoirm féin a shíniú.

Ainm: _____	Sloinne: _____
Seoladh: _____	
Cód Poist/Contae: _____ Uimh.PSP: _____	
Dáta Breithe:(dd/mm/yyyy) ____/____/____ AOIS: _____ Fireann <input type="checkbox"/> Baineann <input type="checkbox"/>	
Ainm an Tuismitheora & Uimhir fóin: _____	

Scoil/Coláiste: _____	Rang/Bliain: _____
Ainm an Dochtúra Teaghlaigh: _____	
Seoladh: _____ Uimhir Theagmhála: _____	

An bhfuil tusa (nó d'inion) sa chéad 14 seachtain de thoircheas?	Tá <input type="checkbox"/>	Níl <input type="checkbox"/>
An bhfuil aon tinneas tromchúiseach ar an té atá ag fáil an vacsaín?	Tá <input type="checkbox"/>	Níl <input type="checkbox"/>
Má tá, cad é? _____		
An bhfuil aon neamhord haemaiteolaíoch/fuiliú agat?	Tá <input type="checkbox"/>	Níl <input type="checkbox"/>
An raibh frithghníomh trom díobhálach (ailléirgeach) riamh agat (ag do mhac/d'inion) d' aon comhábhar vacsaíne m.sh. Uibheacha, Formaildéad, Gentamycin, Thiomersal?	Bhí <input type="checkbox"/>	Ní raibh <input type="checkbox"/>
An raibh Siondróm Guillain Barré riamh ort (ar do mhac/d'inion)?	Bhí <input type="checkbox"/>	Ní raibh <input type="checkbox"/>
An bhfuair an té atá ag fáil vacsaíniú anois an vacsaín roimhe seo?	Fuair <input type="checkbox"/>	Ní bhfuair <input type="checkbox"/>

Tá an bhileog eolais léite agam agus tuigim é.

Aontaím do vacsaíniú dom féin / mo pháiste ainmnithe thuas a bheith imdhíonaithe le dhá dháileog de Phaindéim H1N1 2009.

Síniú:  
(Féin/Máthair/Athair/Caomhnóir Dlíthiúil)  
Cuir ciorcal ar an gceann cuí.  
Dáta: / /

Tá an bhileog eolais léite agam agus tuigim é

DIÚLTAÍM cead a thabhairt don vacsaín dom féin/don pháiste ainmnithe thuas a bheith imdhíonaithe le dhá dháileog a bhaineann le Paindéim H1N1 2009.

Síniú:  
(Féin/Máthair/Athair/Caomhnóir Dlíthiúil)  
Cuir ciorcal ar an gceann cuí.  
Dáta: / /

*Tá a fhios ag an fhoireann faoi na dualgais atá orthu a bhaineann le hAchtanna Cosanta Faisnéise, 1988 agus 2003. Ní úsáidfeair an t-eolas a chuirfeair ar fáil ar an bhfoirm seo ach amháin chun cúram leighis a chur ar fáil agus chun soláthóirí a íoc.*

**FOR OFFICE USE ONLY**

Increased Medical Risk		Yes	Codes (Circle <u>all</u> that apply)										
			a	b	c	d	e	f	g	h	i	j	k
Date Given	Batch No.	Manufacturer	Dose Given	Site Given	Prescribed by Signature & MCRN	Vaccinator's Signature & MCRN/Nurse PIN							
Pandemic Dose 1													
Date Given	Batch No.	Manufacturer	Dose Given	Site Given	Prescribed by Signature & MCRN	Vaccinator's Signature & MCRN/Nurse PIN							
Pandemic Dose 2													

Not Vaccinated  Reason not vaccinated code: (circle as appropriate) A B C D

**Record Card Given :**  **Date Updated on IT System :** / /

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Please tick on front of page if **Increased Medical Risk Patient** and circle all appropriate codes

e.g. Patient is in an **Increased Medical Risk Group** and has **Chronic Respiratory Disease**, is **pregnant (2nd and 3rd trimester)** and has **Chronic Liver Disease**

This is coded as  (a), (b) (e)

**Increased Medical Risk Code**

- a) Chronic Respiratory Disease (including all who received any medical treatment for asthma in past 3 years)
- b) Pregnant women
- c) Chronic Heart Disease
- d) Chronic Renal Disease
- e) Chronic Liver Disease
- f) Chronic Neurological Disease
- g) Immunosuppressed
- h) Household Contacts of Immunosuppressed and household contacts of those < 6 months
- i) Diabetes Mellitus
- j) Morbidly Obese
- k) Haemoglobinopathies

Vaccination under Medication Protocol

**If answer yes to any of the following please refer for individual medical assessment prior to vaccination**

Is patient in first 14 weeks of pregnancy? Yes  No

Is there a contraindication to IM Injection?  
(Haematological disorder/bleeding disorder) Yes  No

Is patient allergic to any of the vaccine components?  
(Eggs, Formaldehyde, Gentamycin etc.) Yes  No

Is there a history of Guillain Barré Syndrome? Yes  No

Referred for individual medical assessment ? Yes

Adverse Reaction? Yes  Adverse Reaction Form Completed? Yes

Incident (including anaphylaxis or medication error/near miss) Yes

Incident Form Completed? Yes

Please tick on front of page if patient not vaccinated and circle appropriate code

- A) Vaccination contraindicated
- B) Vaccination deferred
- C) Vaccine refused
- D) Left prior to being vaccinated