ABBEY MEDICAL CENTRE

41 Russell Street, Reading, RG1 7XD

Assessment and PSD form for use with Moderna Spikevax Bivalent (Original/Omicron) or Spikevax Original vaccine

Name		**Date of birth**	
Surname			
Home address			
		Postcode	

Assessors Name or ID Number	

Please ask the person presenting for vaccination these questions and record that they have received appropriate counselling as to the purpose of the vaccine and side effects

Have you had any vaccination in the last 7 days?	**No** ☐	**Yes** ☐
Are you currently unwell with fever?	**No** ☐	**Yes** ☐
*** Have you ever had any serious allergic reaction?**	**No** ☐	**Yes** ☐
***Have you ever been prescribed an adrenaline autoinjector such as an epipen?**	**No** ☐	**Yes** ☐
Are you, or could you be pregnant, breastfeeding or planning to become pregnant in the next three months?	**No** ☐	**Yes** ☐
Are you or have you been in a trial of a potential coronavirus vaccine?	**No** ☐	**Yes** ☐
Are you taking anticoagulant medication, or do you have a bleeding disorder	**No** ☐	**Yes** ☐

Has the vaccine recipient read the written information provided?	Yes	No
Is the person being assessed happy to receive the Covid-19 vaccine following assessment by a vaccinator?	Yes	No
Does the vaccine recipient agree to be monitored for at least 15 minutes following vaccination as there is a small risk of significant adverse reactions to the vaccine?	Yes	No
Consent given to vaccination (or assent in place on patients' behalf)?	Yes	No