pharmadoctor

Hepatitis B vaccine for occupational health
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

Do you feel unwell, have a temperature or an infection? Yes ☐ No ☐	Do you have a bleeding disorder, including taking any medication that is an anticoagulant? Yes ☐ No ☐
Have you ever had an allergic or anaphylactic reaction to a Hepatitis B injection or any other vaccine before? Yes ☐ No ☐ *If yes, please describe the reaction*	Do you have any allergies? Or had an anaphylactic reaction to latex? Yes ☐ No ☐ *If yes, please describe the allergy/reaction*
Do you have any recent or past medical history of note? Yes ☐ No ☐ *If yes, please provide details*	Are you immunosuppressed due to disease or treatment? Yes ☐ No ☐ *If yes, please provide details*
Do you have a hereditary and degenerative disease of the nervous system or muscles or a severe neurological disability? Yes ☐ No ☐ *If yes, please give details.*	Have you ever had a Hepatitis B vaccine? Yes ☐ No ☐ *If yes, please give dates* Dose 1 Dose 2 Dose 3
Are you pregnant, or is there any possibility that you might be pregnant? Yes ☐ No ☐	Do you have any liver or kidney problems? Yes ☐ No ☐ *If yes, please provide details*
Are you breast-feeding? Yes ☐ No ☐	Have you had a Hepatitis B infection before? Yes ☐ No ☐
Have you completed a full Occupational Health Risk Assessment with your employer? Yes ☐ No ☐	Are you aware that this Health Care Professional is not able provide advice on situations and hazards within your workplace, and necessary arrangements must be made with your employer to discuss these risks?

Please list all your current prescription medication including any medication you buy over the counter.

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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.

Patient signature_____ **Date** _____

Verbal consent: I confirm that the patient, parent or guardian has given verbal consent ☐

Pharmacist signature_____ **Date** _____

HEALTHCARE PROFESSIONAL USE ONLY						
Date	Dose	*Vaccine Brand, Batch number and expiry date (or use labels)*	L or R deltoid	IM or SC*	Healthcare Professional Name & Signature	Cost
	1					
	2					
	3**					
	4 or booster					

***SC** only for those with a bleeding disorder and the professional is competent with the technique

****A** blood test to check the patient's anti-HBs titres must be arranged following primary immunisation

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 USE ONLY

Non-supply/administration

I confirm that the patient did NOT receive the medication ☐

Patient referred to GP ☐

Reason for non-supply/administration