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Santé et Services sociaux Québec

DT9603

FLU AND PNEUMOCOCCUS VACCINATION

Patient's last and first name

Mother's last and first name

Father's last and first name (optionnal)

Date of birth: Year Month Day — Sex: ☐ M ☐ F

Health insurance number — Expiry date: Year Month

Address (number, street)

City — Postal code

GENERAL INFORMATION

Capable user 14 years of age or older

Area code Home phone no | Area code Other phone no. ☐ Cell ☐ Work

Email address:

Patient under 14 years of age or adult incapable of giving consent

Authorized person as they so declare: (last name, first name): | Email address:

☐ Mandatary ☐ Guardian ☐ Curator ☐ Public curator ☐ Spouse (married, civil union, or common law) ☐ Close relative

☐ Person showing a special interest in this adult ☐ Parental authority

Area code Home phone no | Area code Other phone no. ☐ Cell ☐ Work

PRE-IMMUNIZATION QUESTIONNAIRE*

	TO BE CHECKED BY THE VACCINATOR	YES	NO	N/A	DETAILS
1.	**Health problems** (Has the patient experienced any recent changes in their health? Do they have asthma? Are they experiencing severe congestion/runny nose? Are they taking ASA or medications containing it?)	☐	☐	☐	
2.	**Immunosuppression** (Is the patient taking any immunosuppressive medications? Are they immunocompromised or do they have an autoimmune disease?)	☐	☐	☐	
3.	**Previous reactions** (Has the patient ever had a significant reaction to a vaccine or other product that required a visit to the hospital?)	☐	☐	☐	
4.	**Pregnancy** (If the patient is a woman, is she pregnant?)	☐	☐	☐	
5.	**Immunizing products** (Has the patient received a vaccine in the last month?)	☐	☐	☐	
6.	**Contacts** (Is the patient in close contact with a severely immunocompromised person?)	☐	☐	☐	

*For contraindications and precautions, please refer to the *Inf injectable section and Inf intranasal section of the Protocole d'immunisation du Québec.*

ADMINISTRATION REASON (by priority order)

☐ 07 – Influenza – Resident in a CHSLD
☐ 08 – Influenza – Resident in a RPA
☐ 09 – Influenza – Pregnant woman
☐ 10 – Influenza – Healthcare worker
☐ 11 – Influenza – Chronic illness
☐ 12 – Influenza – Others reasons

Patient's last and first name	Record no.

CONSENT/DECISION

- ☐ Information on the benefits and risks of vaccination, possible reactions and what to do after being vaccinated has been given to the patient or their legal representative.
- ☐ The information in the sheet intended for the population targeted by the Protocole d'immunisation du Québec (PIQ) has been communicated to the patient or their legal representative.
- ☐ The patient will be monitored for 15 minutes after they have been vaccinated.

DECISION

The patient or their legal representative:

- ☐ Consents to vaccination against influenza
- ☐ Refuses vaccination against influenza
- ☐ Consents to vaccination against pneumococcus
- ☐ Refuses vaccination against pneumococcus

In the case of an employee of a health institution:

- ☐ Consents to have this information forwarded to the health unit

CONSENT/REFUSAL OBTAINED FROM:

☐ Patient ☐ Mandatary ☐ Guardian ☐ Curator ☐ Public curator ☐ Close relative
☐ Spouse (married, civil union, or common law) ☐ Person showing a special interest in the person ☐ Parental authority

INFORMATION ON THE PROFESSIONAL WHO OBTAINED CONSENT

Full name of the professional:

PROFESSION ☐ Nurse ☐ Physician ☐ Respiratory therapist ☐ Midwife ☐ Pharmacist

Licence no.:	Professional's signature:

PHONE CONSENT
(Complete this section only if consent is obtained by phone.)

			Year	Month	Day
Name of witness:		**Date**			
Signature of the professional who obtained phone consent:		**Date**			

DETAILS OF VACCINATION

Date (year, month, day)	Hour (00:00) of vaccination	Vaccine Name	Batch number	Dose/ unit	Route of administration	Injection Site
		☐ Flulaval Tetra ☐ Fluzone quadrivalent ☐ Fluzone HD quadrivalent		0.5 ml or contents of single-dose format	Intramuscular	☐ Right arm ☐ Left arm ☐ Right thigh ☐ Left thigh
		☐ Flumist quadrivalent		0.1 ml 0.1 ml	Intranasal	☐ Right nostril ☐ Left nostril
		☐ Pneumovax 23		0.5 ml	Intramuscular	☐ Right arm ☐ Left arm ☐ Right thigh ☐ Left thigh

INFORMATION ON IMMUNIZATION PROVIDER

Vaccinator's full name:	Profession: ☐ Nurse ☐ Physician ☐ Respiratory therapist ☐ Midwife ☐ Pharmacist	
Licence no:	Vaccination site (LDS):	Vaccinator's signature:

INFORMATION ON THE PROFESSIONAL WHO ADMINISTERED THE VACCINE (Complete this section only if different from vaccinator)

Full name of professional who administered the vaccine:	Profession: ☐ Nurse practitioner ☐ Other, specify: _____	Licence no:

Notes

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