



DT9498

COVID-19 VACCINATION

Patient's last and first name					
Mother's last and first name					
Father's last and first name (optional)					
Date of birth		Year	Month	Day	Sex
					<input type="checkbox"/> M <input type="checkbox"/> F
Health insurance number			Year		
			Month		
Expiry date					
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.	<input type="checkbox"/> Cell	<input type="checkbox"/> Work
Email address:					

User under 14 years of age or incapable adult

Authorized person as they so declare: (last name, first name):			Email address:		
<input type="checkbox"/> Mandatory	<input type="checkbox"/> Guardian	<input type="checkbox"/> Curator	<input type="checkbox"/> Public curator	<input type="checkbox"/> Spouse (married, civil union, or common law)	<input type="checkbox"/> Close relative
<input type="checkbox"/> Person showing a special interest in this adult	<input type="checkbox"/> Parental authority				
Area code	Home phone no	Area code	Other phone no.	<input type="checkbox"/> Cell	<input type="checkbox"/> Work

PRE-IMMUNIZATION QUESTIONNAIRE*

	TO BE CHECKED BY THE VACCINATOR	YES	NO	N/A	DETAILS
1.	Health problems (Does the patient present symptoms compatible with COVID-19? Has the patient recently noticed a change in his/her state of health? Has the patient ever had a positif test for COVID-19? Does the user have a health condition that requires medical monitoring or regular medication?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Immunosuppression (Is the patient taking any immunosuppressive medications? Is he immunocompromised or does he has an autoimmune disease?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Previous reactions (Has the patient ever had a significant reaction following the administration of a vaccine or other product that required a visit at the hospital?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Pregnancy (If the patient is a woman, is she pregnant?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5.	Bleeding disorder (Does the patient suffer or has he ever suffered from a bleeding disorder (ex. : thrombosis, thrombocytopenia) requiring medical follow-up or is he taking anticoagulant medications?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.	Immunization or blood products (Has the patient received a vaccine in the last 14 days? Has the patient received plasma from convalescent COVID-19 patients or monoclonal antibodies against COVID-19?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

* For contraindications and precautions, please refer to the *Vaccin contre la COVID-19 section of the Protocole d'immunisation du Québec.*

ADMINISTRATION REASON (by priority order)

<input type="checkbox"/> 01 - COVID-19 - Resident in public or private long-term health care facility (CHSLD)	<input type="checkbox"/> 04 - COVID-19 - Health care worker
<input type="checkbox"/> 02 - COVID-19 - Resident in private seniors' residence (RPA)	<input type="checkbox"/> 05 - COVID-19 - Chronically ill
<input type="checkbox"/> 03 - COVID-19 - Pregnant woman	<input type="checkbox"/> 06 - COVID-19 - Others reasons

User's last and first name

Record no.

CONSENT/DECISION

- Information on the benefits and risks of vaccination against COVID-19, possible reactions, and what to do after being vaccinated has been given to the patient or his/her 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 his/her legal representative.
- The patient will be monitored for 15 minutes after he/she has been vaccinated.
- The patient will be monitored for 30 minutes after he/she has been vaccinated.

DECISION

The patient or his/her legal representative:

In the case of an employee of a health institution :

- Consents to vaccination against COVID-19 Consents to have this information forwarded to the health unit
- Refuses vaccination against COVID-19
- Consent obtained upon administration of the first dose

CONSENT/REFUSAL OBTAINED FROM:

- Patient Mandatory Guardian Curator Public Curator Close relative
- Spouse (married, civil union, or common law) Person showing a special interest in the patient 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.)****Name of witness:****Date**

Year Month Day

Signature of the professional who obtained phone consent:**Date**

Year Month Day

DETAILS OF VACCINATION *(to be completed if not entered in SI-PMI in real time)*

- First dose Second dose Additional dose

Date (year, month, day)	Hour (00:00) of vaccination	Vaccine Name	Batch number	Dose/ unit	Route of administration	Injection Site
					Intramusculaire	<input type="checkbox"/> Right arm <input type="checkbox"/> Left arm <input type="checkbox"/> Right thigh <input type="checkbox"/> 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)*

Professional who administered the vaccine's full name:

Profession:

- Practical Nurse Other, specify: _____

Licence no.:

Notes