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Santé et Services sociaux Québec

DT9498

COVID-19 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:

User under 14 years of age or incapable adult

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

☐ Mandatary ☐ Legal representative ☐ 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 or IDK	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 positive test for COVID-19? Does the user have a health condition that requires medical monitoring or regular medication?	☐	☐	☐	
2.	**Immunosuppression** Is the patient taking any immunosuppressive medications? Is he immunocompromised or does he has an autoimmune disease?	☐	☐	☐	
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?	☐	☐	☐	
4.	**Pregnancy** If the patient is a woman, is she pregnant?	☐	☐	☐	
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?	☐	☐	☐	
6.	**Immunization or blood products** Has the patient received plasma from convalescent COVID-19 patients or monoclonal antibodies against COVID-19?	☐	☐	☐	

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

Legend: N/A :Not applicable
IDK : I dont' know

ADMINISTRATION REASON (by priority order)

☐ 01 - COVID-19 - Resident in public or private long-term health care facility (CHSLD)
☐ 02 - COVID-19 - Resident in private seniors' residence (RPA)
☐ 03 - COVID-19 - Pregnant woman
☐ 04 - COVID-19 - Health care worker
☐ 05 - COVID-19 - Chronically ill
☐ 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:

- ☐ Consents to vaccination against COVID-19
- ☐ Refuses vaccination against COVID-19
- ☐ Consent obtained upon administration of the first dose
- ☐ Not applicable

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 ☐ Legal representative ☐ 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.)

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

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

☐ Primary vaccination ☐ Booster dose ☐ Other _____

Date (year, month, day)	Hour (00:00) of vaccination	Vaccine Name	Batch number	Dose/ unit	Route of administration	Injection Site
					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)

Professional who administered the vaccine's full name:	Profession: ☐ Practical Nurse ☐ Other, specify: _____	Licence no:

Notes