**Devon Covid Vaccine Allergy Referral Form**

Please use this referral form:

* following a suspected allergy to any Covid vaccine
* **or** if the patient has a suspected allergy to another substance (vaccine, PEG, vaccine excipient) that raises concern about future Covid vaccination.

**It is expected that the healthcare professional who has identified a potential risk to a patient receiving a Covid vaccination should, wherever possible, take responsibility for completing this form.**

Please complete the form as fully as possible. Failure to do so risks the referral being returned.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Section A: Patient Details** | | | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | | | | | | | Date of Birth: | | | | | | |  | | |
| Address: | |  | | | | | | | | | | GP Surgery: | | | | | | |  | | |
| Postcode: | |  | | | | | | | | | | Date of referral: | | | | | | |
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| **Section B: COVID Vaccination Status** | | | | | | | | | | | | | | | | | | | | | |
| Has the patient received a COVID Vaccine? | | | | | YES | |  | | | NO |  | |  | Date: | | |  | | | | |
| If yes, which one? | | | | |  | | | | | | | | | Batch No  (if known): | | |  | | | | |
| Which category is the patient in? (circle one) | | | | | | | | | | | | | | | | | | | | | |
| 1  Care Home Resident | 2  Aged over 80 | | 2  Health & Social care worker | | | 3  Aged over 75 | | 4  Aged over 70 | | | 4  Clinically Extremely Vulnerable | | | 5  Aged over 65 | 6  Underlying health conditions | | | 7  Aged over 60 | | 8  Aged over 55 | 9  Aged over 50 |
| Other (please explain): | | | |  | | | | | | | | | | | | | | | | | |
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| **Section C: Suspected Allergen** | | | | | | | | | | | | | | | | | | | | | |
| Was the suspected allergic reaction after the COVID Vaccine? | | | | | | | | | | | | | | | YES | |  | NO | |  |  |
| If No, please provide as much detail as possible regarding the drug, vaccine or vaccine excipient that prompted the suspected allergic reaction… | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Year/date of reaction (approx.): | | | | | | |  | | | | | | | | | | | | | | |
| How long after the suspected allergen did the reaction occur? | | | | | | |  | | | | | | | | | | | | | | |
| Has the patient tolerated any vaccines since the suspected reaction? (If yes, which one(s)? | | | | | | |  | | | | | | | | | | | | | | |
| Has the patient previously tolerated an injectable influenza vaccine? | | | | | | | | | | | | | | YES | |  | NO | |  | |  |
| **Section D: Suspected Reaction** | | | | | | | | | | | | | | | | | | | | | |
| How quickly did the reaction start after exposure to the suspected allergen? | | | | | | | | | | | | | | | | | |  | | | |
| Please categorise the reaction (Please tick all that apply): | | | | | | | | | | | | | | | | | | | | | |
| * + 1. Anaphylaxis/cardiac/respiratory compromise | | | | | | | | | | | | | | | | | | | | |  |
| * + 1. Rash or swelling distant from the site of injection | | | | | | | | | | | | | | | | | | | | |  |
| * + 1. Large local swelling, heat and tenderness at site of injection only | | | | | | | | | | | | | | | | | | | | |  |
| * + 1. Patient hospitalised or required adrenaline | | | | | | | | | | | | | | | | | | | | |  |
| Please give additional details: | | | | | | | | | | | | | | | | | | | | | |
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| **Section E: Other required Information** | | | | | | | | | | | | | | | | | | | | | |
| Please provide a list of current medications: | | | | | | | | |  | | | | | | | | | | | | |
| Please list any known drug allergies: | | | | | | | | |  | | | | | | | | | | | | |
| Does the patient have any of the following medical conditions (please tick): | | | | | |  | Chronic lung disease (e.g., COPD/Asthma) – if yes please provide baseline Peak Flow or FEV1: | | | | | | | | | | | | | | |
|  | Heart disease | | | | | | | | | | | | | | |
|  | Other relevant condition (please list) | | | | | | | | | | | | | | |
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