**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: |
|  |
| **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) |
| 1Care Home Resident | 2Aged over 80 | 2Health & Social care worker | 3Aged over 75 | 4Aged over 70 | 4Clinically Extremely Vulnerable | 5Aged over 65 | 6Underlying health conditions | 7Aged over 60 | 8Aged over 55 | 9Aged over 50 |
| Other (please explain): |  |
|  |
| **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:  |
|  |
|  |
| **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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