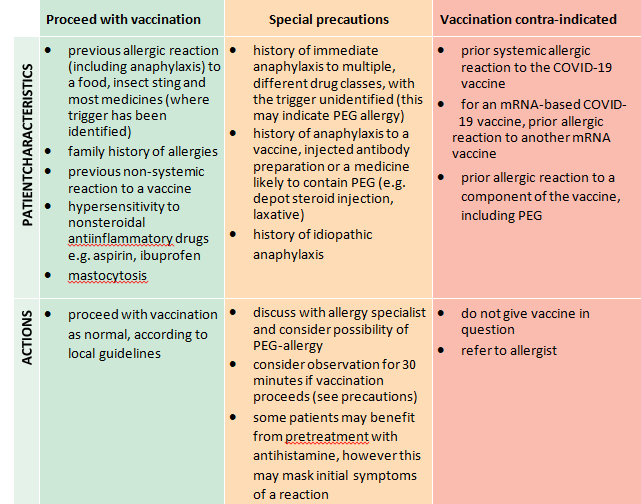
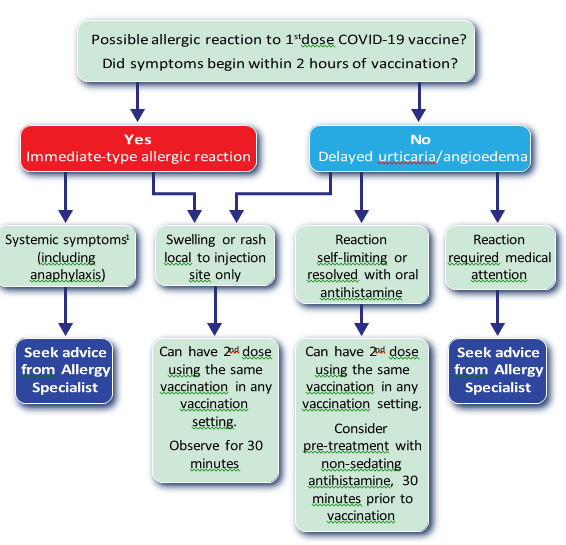
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**Request for Advice and Guidance for Covid-19 vaccination**

There are very few individuals who cannot receive the Pfizer BioNTech, Moderna or AstraZeneca COVID-19 vaccines. Where there is doubt, rather than withholding vaccination, appropriate advice should be sought. Please refer to the Green Book for detailed advice <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/955548/Greenbook_chapter_14a_v6.pdf>

The tables below summarise the clinical actions required for the ***Management of patients with a history of allergies*** *a*nd for those patients who have a ***Possible allergic reaction to 1st dose of COVID-19 vaccine.***

**Figure 1 Management of patients with a history of allergy Figure 2 managing patients who have allergic reactions to the first dose of COVID-19 vaccine**

** **

This form is to be used to support an Advice and Guidance request re Covid-19 vaccination for a patient who is deemed to be high clinical concern due to either a history of allergy/anaphylaxis or a possible allergic reaction to 1st dose of COVID-19 vaccine. It is intended to ensure a prompt response and clear guidance around the following key questions:-

1. **Which Vaccine can I give?**
2. **Where should the vaccine be administered community/hospital?**
3. **Should the patient be advised to take an antihistamine pre vaccination?**

All requests need to be made via A&G to the dedicated Allergy Service at UHS, using the **New Service details:- COVID Vaccine Concern- (Advice & Guidance)- Southampton-UHSFT-RHM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient Name:** |  | **Contact Number:** |  | **NHS Number:** |  |
| **Date of Birth:** |  | **Email Address:** |  | **GP:** |  |  |  |
| **Address:** |  |  |  | **GP Address:** |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name and Role of Requester** |  | | | |
| **Date of Request:** |  | | | |
|  | | | | |
| Date and details of Dose 1 vaccination given |  | | | |
|  | | | | |
| Adverse event details- please include full details |  | | | |
|  | | | | |
| Date dose 2 needed (12-week schedule) |  | | | |
|  | | | | |
| Dose 1 query |  | | | |
| **Questions** | | | | |
| 1.Has this patient seen any Allergist in UHS within past 5 years | | **Unsure** | **No** | **Yes who/when** |
|  | | | | |
| 2.Has the patient been an inpatient (not just A&E) at UHS/UBH/PHU  within past 5 years and are they under any current specialist OPD team eg Respiratory (if so what team(s) | | **Unsure** | **No** | **Yes** |
|  | | | | |
| 3.Has the patient got a clear history of anaphylaxis (resus council definition) or Severe allergy (immediate onset, multisystemic reaction) to any of the following:-   * Drugs/vaccines * cancer drug/monoclonal or vaccine * depo steroid (eg Joint injection) or depo hormone treatment * Any labelled ADR to drugs not covered by above of episode | | **Unsure** | **No** | **Yes Please give the following information if applicable**   * **Drug Name (manufacture dose/route)** * **Symptoms, documented use of adrenaline, location of reaction/management (own home/GP/A&E/inpatient – which hospital)** |
|  | | | | |
| 4. What are co-morbidities which make vaccination priority?  What are the current major health concerns (asthma, CVD, immunodeficiency – any/all the CEV indications) | |  | | |
|  | | | | |
| 5. Advise us of the following:-   * Hx of Significant anxiety/mental health diagnoses and particularly of any history of “mast cell activation syndrome”/EhlerDanlos/Chronic fatigue/Fibromyalgia * List of current medication (include if patient has even been prescribed an **Epipen?**   Any communication concerns (eg need for translator) /learning difficulties/dementia (anything which might affect ability to consent patient properly by phone) | |  | | |