AQPP
Association québécoise des pharmaciens propriétaires

# Pharmacy Assessment and Vaccination Questionnaire

**Section A:**
**To be completed by the pharmacy**

| Patient identification | | |
|---|---|---|
| Affix the identification label including:<br>full name, address and telephone number | Date (DD/MM/YYYY) | |
| | Time | |
| | Managed by | |
| | Vaccines (PQI or private) | |

**Section B:**
**To be completed by the patient**

| Patient Information | |
|---|---|
| Date of birth (DD/MM/YYYY) – Age | |
| Health insurance number | |
| Emergency contact (Name and phone number) | |

| Medical Information | | |
|---|---|---|
| *Please check the appropriate box for the following questions* | Yes | No |
| Do you have allergies? Examples: latex, thimerosal, eggs, gelatin.<br>If yes, specify: | | |
| Do you have intolerances?<br>If yes, specify: | | |
| Have you ever had a serious allergic reaction requiring emergency care?<br>If yes, specify: | | |
| Have you ever experienced dizziness or lost consciousness while getting a vaccine? | | |
| Have you ever had a reaction to vaccine that required medical attention? If yes, specify: | | |
| Do you have a weakened immune system due to a medical condition or to a medication? If yes, specify: | | |
| Do you have a hematological (coagulation) disorder? | | |
| Have you received a blood transfusion or an injection of immunoglobulins over the past year? | | |
| Do you currently have a fever or have you had one in the last 24 hours? | | |
| If applicable, are you pregnant or do you think you might be? | | |

| Additional Comments |
|---|
| |
| |

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## Pharmacy Assessment and Vaccination Questionnaire (Continued)

**Section C:**
**To be completed by the healthcare professional**

| Identification of the Healthcare Professional | | |
|---|---|---|
| | Identification of the prescriber | Identification of the vaccinator (if different from the prescriber) |
| Last name, First name | | |
| Licence number | | |

| Validation List | | |
|---|---|---|
| *Elements to be validated* | Yes | No |
| Consent was obtained from the patient or his/her guardian. | | |
| The eligibility criteria for the PQI (covered) for influenza, pneumococcus or other have been verified. | | |
| The explanations, risks and benefits have been given to the patient or his/her guardian. | | |
| The absence of contraindications has been validated. | | |
| The immunization history and schedule have been validated to ensure that the vaccine is administered at the recommended time. | | |
| All of the patient's questions were answered. | | |

**I confirm that I have received the explanations relating to the benefits and effects of the vaccine. I have been advised to remain on site for a minimum period of fifteen (15) minutes after receiving the vaccine.**

_____
**Patient signature**

_____
**Date**

| Vaccines Administered | |
|---|---|
| Affix the vaccine label including:<br>product name, DIN, batch number,<br>expiration date, injection site and technique, dose administered | Affix the vaccine label including:<br>product name, DIN, batch number,<br>expiration date, injection site and technique, dose administered |

| Post-Vaccination Surveillance | | |
|---|---|---|
| *Tasks to perform* | Yes | No |
| Remind the patient of possible side effects. | | |
| Document the patient file. | | |
| Record the vaccines administered in the Vaccination Registry and patient's vaccination record. | | |

_____
**Healthcare professional signature**

_____
**Print name**

_____
**Date**