**COVID-19 Vaccination Referral Form**



**NHSGGC: Return form to** **ggc.covidvaccinationcontactcentre@ggc.scot.nhs.uk**

**Please insert patient name & CHI in subject heading. One email per patient.**

|  |  |
| --- | --- |
| Email: |  |
| Specialty: |  |

Date of Referral:

|  |  |  |
| --- | --- | --- |
| Referring Clinician Name: |  |  |
| Responsible Consultant/GP: |  |
| Referring Hospital/ GP Practice: |  |
| Patient Name: |  |
| CHI: |  |
| Telephone Number: |  |

|  |
| --- |
| **Reason for Early second dose** |
| * Awaiting Transplant:
 | ☐ |
| * Commencing Immunosuppressive Therapy:
 | ☐............ |
| * Other …
 |  |
| If new treatment/surgery, anticipated start date: |  |
| * Date of first dose:
 |  |
| * Preferred timeframe for second dose
 |  |
|  |  |
|  **Reason for third primary dose** * primary or acquired immunodeficiency states;

 immunosuppressive or immunomodulating therapy; chronic immune-mediated inflammatory disease who were receiving or had received immunosuppressive therapy prior to vaccination;Individuals who had received high dose steroids (equivalent to >40mg prednisolone per day for more than a week) for for any reason in a month before vaccination.* **Other**
 |  **☐** **☐** **☐**  **☐** **………………………………………………** |
| * Date of second dose
 |  |
| * Preferred timescale for third dose
 |  weeks |
|  |  |
| **Referral for first dose for 5-11 year old** |  |
|  Reason for First dose ( as per Green Book )  |  |
|  Any treatment dates to avoid  |  |
|  Any additional needs eg quiet area  |  |

|  |
| --- |
| Any other comment: |
|  |
| **Please note that you should send your referral for vaccination to the Health Board of your patient’s residence rather than where the person is attending for clinical care** |