

EMR User Guide

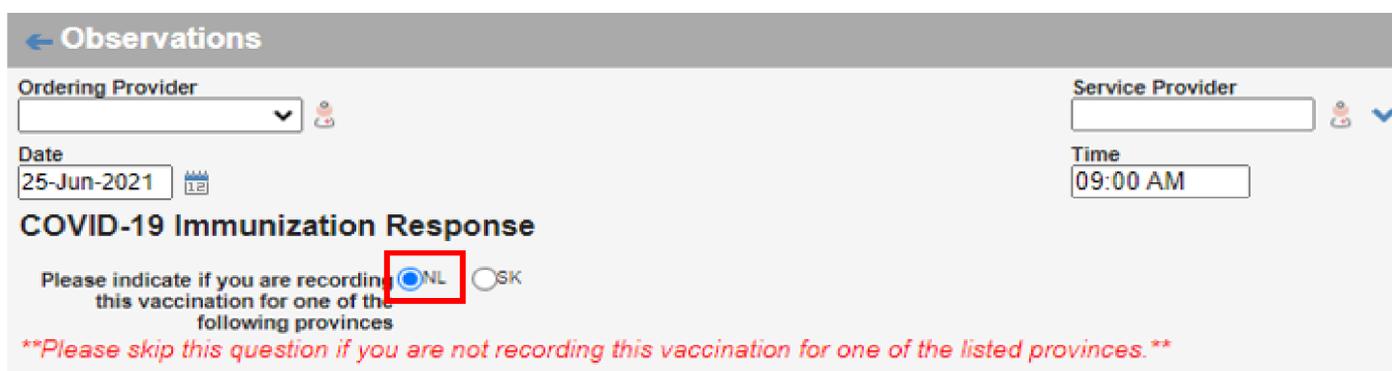
National COVID-19 Vaccine Template



The EMR consent and vaccination template for COVID-19 immunizations has been enhanced to meet provincial and national documentation and reporting requirements. These new changes are necessary as the province moves to expand the COVID-19 immunization campaign.

Getting Started

Once you have the COVID-19 vaccine template opened, **ensure that you select NL for the first question**. This is a very important step as it will change the format of the form to reflect questions specific to Newfoundland and Labrador and will allow the data to be properly captured.



← Observations

Ordering Provider: [dropdown]

Date: 25-Jun-2021 [calendar icon]

Service Provider: [dropdown]

Time: 09:00 AM

COVID-19 Immunization Response

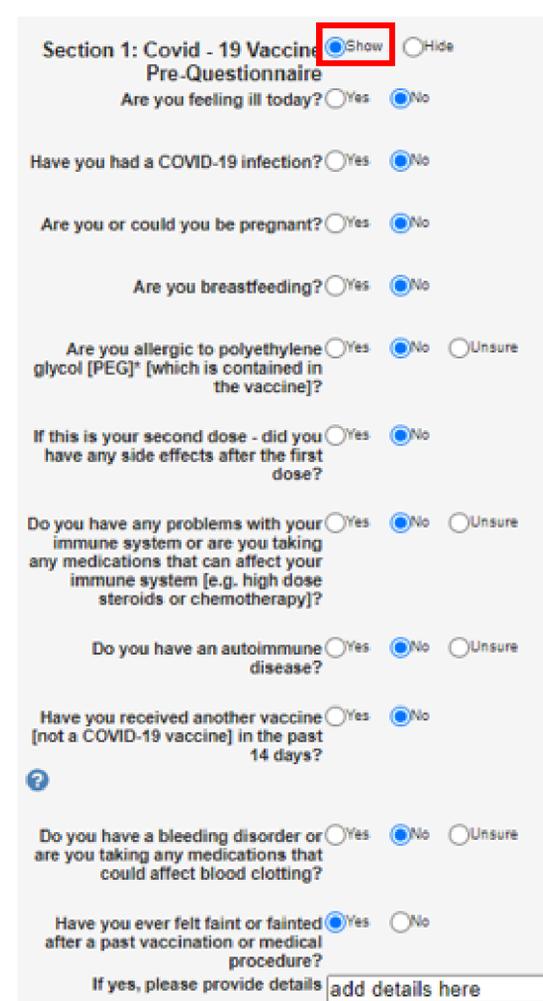
Please indicate if you are recording this vaccination for one of the following provinces: NL SK

Please skip this question if you are not recording this vaccination for one of the listed provinces.

Complete the Form

Section 1: COVID-19 Vaccine Pre-Questionnaire

- Click **Show** to display the questions
- Complete **ALL** pre-questionnaire questions, recording answers provided by patient/caregiver
- If **Yes** is selected for any question, an additional field will appear where you can enter additional details



Section 1: Covid - 19 Vaccine Pre-Questionnaire Show Hide

Are you feeling ill today? Yes No

Have you had a COVID-19 infection? Yes No

Are you or could you be pregnant? Yes No

Are you breastfeeding? Yes No

Are you allergic to polyethylene glycol [PEG]* [which is contained in the vaccine]? Yes No Unsure

If this is your second dose - did you have any side effects after the first dose? Yes No

Do you have any problems with your immune system or are you taking any medications that can affect your immune system [e.g. high dose steroids or chemotherapy]? Yes No Unsure

Do you have an autoimmune disease? Yes No Unsure

Have you received another vaccine [not a COVID-19 vaccine] in the past 14 days? Yes No

Do you have a bleeding disorder or are you taking any medications that could affect blood clotting? Yes No Unsure

Have you ever felt faint or fainted after a past vaccination or medical procedure? Yes No

If yes, please provide details:

Section 2: Consent

- Click **Show** to display the questions
- Select **Yes** for 'Obtained informed vaccination consent?' if the vaccine is administered. In this case, complete **ALL** questions on the form

Section 2: Consent Show Hide

Vaccine consent disclaimer I have read (or it has been read to me) and I understand the COVID-19 Vaccine Information Sheet. I have had the opportunity to ask questions and to have them answered to my satisfaction. I have had the opportunity to speak with a healthcare worker regarding any special considerations that apply to me in respect of the COVID-19 vaccine. I consent to receiving the vaccine.

*Obtained informed vaccination consent? Yes No

Consent obtained by

- Select **No** for 'Obtained informed vaccination consent?' if the vaccine is **NOT** administered. In this case, not all fields of the form are mandatory. If the vaccine is not administered to the patient, indicate why the vaccine was not administered in the **Observations** field of 'Section 4: Vaccine Administration'

Section 2: Consent Show Hide

Vaccine consent disclaimer I have read (or it has been read to me) and I understand the COVID-19 Vaccine Information Sheet. I have had the opportunity to ask questions and to have them answered to my satisfaction. I have had the opportunity to speak with my primary care provider regarding any special considerations that apply to me in respect of the COVID-19 vaccine. I consent to receiving the vaccine.

*Obtained informed vaccination consent? Yes No

Consent obtained by

Section 3: Additional Questions / Eligibility Show Hide

Section 4: Vaccine Administration Show Hide

Vaccine administered by external provider

Vaccine AstraZeneca COVID-19 Vaccine COVISHIELD Vaccine Janssen COVID-19 Vaccine Moderna COVID-19 Vaccine Pfizer-BioNTech COVID-19 mRNA Vaccine

Series # 01 02

Dose mL

Lot #

Expiry date

Site Left arm Right arm Left thigh Right thigh

Route

Date given

Time given

Observations

Section 3: Additional Questions/Eligibility

- Click **Show** to display the questions and complete the questions in this section
- If **Indigenous** is selected for race, an additional question will appear below where you can identify the patient's indigenous identity/group



Section 3: Additional Questions / Eligibility Show Hide

Race / ethnicity [please check the applicable boxes] Black [e.g. Africa; Afro-Caribbean; African Canadian descent] East/Southeast Asian [e.g. Chinese; Korean; Japanese; Taiwanese descent or Filipino; Vietnamese; Cambodian; Thai; Indonesian; other Southeast Asian descent] Indigenous [e.g. First Nations; Inuk/Inuit; Metis descent] Latino [e.g. Latin American; Hispanic descent] Middle Eastern [e.g. Arab; Persian; West Asian descent—i.e. Afghan; Egyptian; Iranian; Lebanese; Turkish; Kurdish] South Asian [e.g. South Asian descent—i.e. East Indian; Pakistani; Bangladeshi; Sri Lankan; Indo-Caribbean] White [e.g. European descent] Other Prefer not to answer Unknown

Unmatched selected values: []

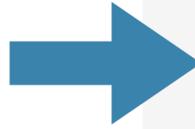
If indigenous indicate indigenous identity LABRADOR INUIT LAND CLAIMS AGREEMENT MIAWPUKEK FIRST NATION MI'KMAQ FIRST NATION ASSEMBLY OF NL MUSHUAU INNU FIRST NATION NUNATUKAVUT INUIT QALIPU FIRST NATION SHESHATSHIU INNU FIRST NATION INDIGENOUS COMMUNITY-BUT NONE OF THE ABOVE

Unmatched selected values: []

Do you live in a group living setting such as long-term care facility; group home; or shelter? Yes No Not certain Prefer not to answer

Please indicate the name of the facility

- If **Yes** is selected for 'Are you a healthcare worker', indicate the patient's occupational setting (e.g., RHA, private practice, etc.). Depending on the option selected, additional fields may appear



What is your occupation?

- Management occupations
- Business, finance and administration occupations
- Natural and applied sciences and related occupations
- Health occupations
- Occupations in education, law and social, community and governing services
- Occupations in art, culture, recreation and sport
- Sales and service occupations
- Trades, transport and equipment operators and related occupations
- Natural resources, agriculture and related production occupations
- Occupations in manufacturing and utilities
- Other
- Prefer not to answer

Unmatched selected values: []

Do you identify as a first responder? Yes No Unsure

Do you identify as a rotational worker? Yes No Unsure

Do you identify as an essential worker? Yes No Unsure

Are you employed in

- The K-12 school setting as a teacher/staff member
- The trucking industry with regular interprovincial or international travel
- Daycare setting as a teacher or staff member
- Other

Unmatched selected values: []

Are you a healthcare worker? Yes No

Please indicate if

- RHA
- Private
- Indigenous Organization
- Government

Unmatched selected values: []

Employee ID

RHA region (RHA)

- CH
- EH
- LGH
- WH

Unmatched selected values: []

- Select the applicable option from the Vaccine Distribution **Source Depot** drop-down list. Proceed to select the applicable **Program** and **Site** from the lists that appear below. These fields will be specific to your clinic and the information should be available on a tent card at your station from the clinic lead

Vaccine Distribution

Source Depot

Clarenville Depot - Program

Clarenville Depot - Acute Care - Site

Section 4: Vaccine Administration

- Click **Show** to display the questions
- If the patient has received a **COVID-19** vaccine from outside of Newfoundland and Labrador, check the **Vaccine administered by external provider** checkbox and complete the 3 additional questions that appear. Alternatively, if the patient has **not** received a COVID-19 vaccine out of province, **do not** check this checkbox

Section 4: Vaccine Administration Show Hide

Vaccine administered by external provider

Given by (Name)

Given by (Designation)

*Country received Canada United States Other

*Province AB BC MB NB NL NS ON PE QC SK NT NU YT

- Proceed to select the name of the current **Vaccine** being administered. Once selected, the **Dose** quantity will auto-populate
- For **Series**, indicate if it is the patient's first or second dose
- Manually enter the vaccine **Lot #**, **Expiry date**, and **Date given**
- Select the **Site** and enter any any additional comments in the **Observations** field

Section 4: Vaccine Administration Show Hide

Vaccine administered by external provider

*Vaccine AstraZeneca COVID-19 Vaccine COVISHIELD Vaccine Janssen COVID-19 Vaccine Moderna COVID-19 Vaccine Pfizer-BioNTech COVID-19 mRNA Vaccine

*Series # 1 2

*Dose mL

*Lot #

*Expiry date

*Site Left arm Right arm Left thigh Right thigh

*Route

*Date given

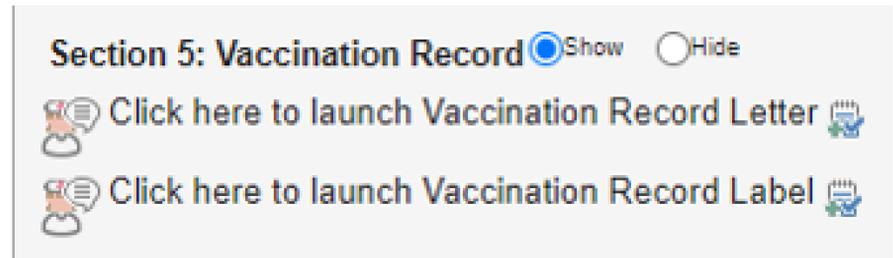
Time given

Observations

Click the blue save icon before opening any tasks in Section 5

Section 5: Vaccination Record

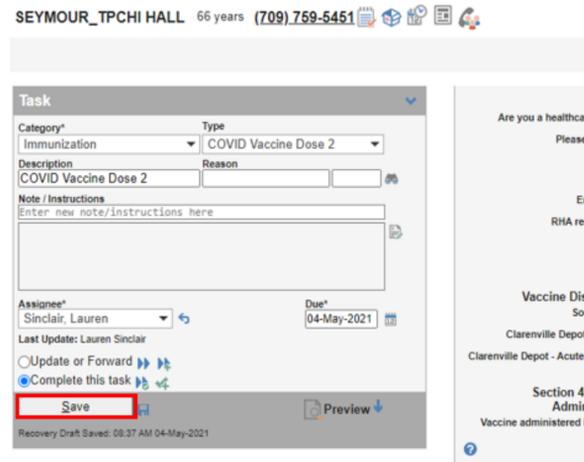
- Click **Show** to display the content. Here you will see 2 items as follows:
 - Vaccination Record Letter**- click this item to display a record of the vaccination administered
 - Vaccination Record Label**- click this item to display the vaccine label



Save and Complete the Task

To finalize and save the form:

- Select **Complete this task**
- Click the **Save** button. You will be returned to the daysheet



Print the Immunization Record and After Care Instructions

To print the immunization record and after care instructions:

- Locate the patient's name on the daysheet and click the **person icon** next to the needle icon

09:35					
09:40	379541291082	SEYMOUR_TPCHI HALL 08-May-1954 (66) M			COVID Vaccine Dose 1
09:50					

- Complete the information at the top of the 'COVID-19 Vaccine After Care and Immunization Record' form
- Click the **printer icon** in the top right corner to print the form
- Click the **Save** button to complete and save the task

