

# User Guide

## Med Access: Influenza Consent and Immunization Documentation

### Influenza Consent and Immunization Documentation

1. Identify patient's name on the daysheet and click on the needle icon to open the Influenza consent form.
2. The external provider question is **only** completed by designated staff for back entry documentation of influenza vaccine administered outside of the RHA.

11:00		<b>Peppa Pig</b> 14-Feb-1951 (71) F		Flu Immunization
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Are you vaccinating on behalf of an external employer?  Yes  No

### Flu Vaccine Information:

1. Select **'SHOW'** for screening questions to appear. The screening questions are inclusive to all Influenza products and if **'YES'** is selected for either question users can document in the textbox located adjacent to the screening question.

**Please note: the consent/immunization form is revised when required. You may notice questions added, removed or altered over time.**

**Flu Vaccine Information**

Screening Questions  Show  Hide

NOTE: Children 6 months to less than 9 years of age receiving influenza vaccine for the first time are recommended to receive two doses of vaccine spaced at least four weeks apart.

If your Child is less than 9 years of age, are they receiving the flu shot for the first time? (see statement above in bold)  Yes  No  Unsure

Do you or your child have a history of allergies? (medications or vaccine or eggs or foods)  Yes  No  Unsure

Are you pregnant?  Yes  No  Unsure

Do you or your child have any past or present medical conditions?  Yes  No  Unsure

Have you or your child ever had a reaction to the flu shot before? (red eyes or hives or rash or difficulty breathing)  Yes  No  Unsure

Did you receive a COVID-19 vaccine in the past 28 days?  Yes  No  Unsure

Are you sick or do you have a fever today?  Yes  No  Unsure

Have you ever had the flu shot before?  Yes  No  Unsure

Adverse Reactions:  
1. Common side effects with injection are soreness and redness at the injection site that may last up to 2 days.  
2. Less frequent side effects include headache, muscular aches/pains, red eyes, cough, irritability and sore throat.  
3. Allergic reactions such as hives/itching and loss of consciousness may occur with extreme sensitivity to certain components of the vaccine.

2. If client is an employee of an RHA then proceed to complete all documentation once **'YES'** is selected.

Do you work for a Regional Health Authority?  Yes  No

If yes, please specify employee type  Contracted physician  Medical resident/intern/clerk  RHA Employee  Student/volunteer/other

Please indicate Employee #

Please indicate RHA  CH  EH  LGH  WH

CH facility

3. Select **'Region'** of vaccine administration, the clinic or **'Location Type'** of where client is receiving vaccine and **Vaccine Depot** information.

What region is this being administrated in?  CH  EH  LGH  WH

Location Type

Source Depot

Central Health Vaccine Depot - Program

Central Health Vaccine Depot - Public Health - Site

**Depot** – The regional depot for your area that ships vaccine

**Program** – The healthcare setting/program for which the vaccine was used

**Site** – Where the vaccine is shipped/stored

(Example: Main depot in Central region is Central Health Vaccine Depot – the program for which vaccine was used is Public Health and the site where vaccine was shipped is the Community Health Building)

4. 'YES' must be selected for consent if immunization administered. If an alternate decision maker provided consent this should be documented in the textbox located adjacent to the consent field. If client is not eligible and/or immunization is not administered follow the guide for "[Documentation of Immunization not Administered](#)".

\*The patient or designate indicates consent  Yes  No  Contraindicated Parent

## Vaccine Administration:

1. If the client is a child under the age of 9 years, indicate if immunization is child's first or second dose, if applicable.
2. If vaccine is administered, all sections of the vaccine information should be completed. As vaccine products become approved by Health Canada they will be added to the consent form. Dose volume will default based on product selected.
3. To save the consent click on **Save** located within the task field. If there are mandatory fields left blank, users will be prompted with a message and consent will not save.

\*If this is a child please indicate if a second dose is needed  Yes  No  Not Applicable  
 If yes, which dose is child receiving today:  Dose 1  Dose 2

**Vaccine Administration**

\*If this is a child please indicate if a second dose is needed  Yes  No  Not Applicable

\*Vaccine  Fluzone  Fluzone HD  FluLaval

\*Dose  mL

\*Injection Site  Left Arm  Left Thigh  Right Arm  Right Thigh

\*Lot #

\*Date given day

\*Date given month

\*Date given year

Method

**Task**

Category\*  Type

Description  Reason

Note / Instructions

Progress Indicators

Assignee\*  Start  Due\*

Last Update: IMM TEST Account

Update or Forward  Complete this task

Urgency  Recurrence

Recovery Draft Saved: 01:58 PM 17-Aug-2022