



## Administration (or supply) of Typhoid Polysaccharide vaccine under Patient Group Direction

**Pharmacy Name : Pyramid Pharmacy**

Address : 413 Hoe Street, E17 9AP

### Patient details

First Name : ..... Surname : .....

Address : .....(no regular address [ ])

Post code : .....

DOB : ..... Gender : ..... NHS No : .....

Ethnicity (print separately): .....

Tel : ..... Mobile : ..... Email : .....

GP : .....

**Patient Consent : I have had a consultation with the pharmacist and consent to receive the Typhoid Polysaccharide vaccine.I also have had an opportunity to ask any questions regarding the consultation.**

Signed:.....

Date :.....

### Reason for inclusion

[ ] Patients over 2 years of age, visiting areas where typhoid is endemic, particularly if they will be staying with or visiting the local population, or if there will be frequent and/or prolonged exposure to conditions where sanitation and food hygiene are likely to be poor.

### Patient medication and comments

### Reasons for exclusions

Known hypersensitivity to components of the vaccine in particular: Formaldehyde - TYPHIM Vi®; Phenol - Typherix [ ]Yes [ ]No

All vaccines are contraindicated in those who have had: [ ]Yes [ ]No  
- A confirmed anaphylactic reaction to a previous dose of a vaccine containing the same antigens, or  
- A confirmed anaphylactic reaction to another component contained in the relevant vaccine, e.g. neomycin, streptomycin or polymyxin B (which may be present in trace amounts in some vaccines): check the SmPC for the individual vaccine to confirm excipients.

Pregnant women should be referred to their GP for advice; [ ]Yes [ ]No

Breastfeeding women should be referred to their GP for advice; [ ]Yes [ ]No

In individuals with an evolving neurological condition, immunisation should be deferred until the neurological condition has resolved or stabilised; [ ]Yes [ ]No

Patients with impaired immunity: the immune response could be impaired by immunosuppressive treatment or in immunodeficiency states: patients should be referred to their GP for advice; [ ]Yes [ ]No

Post-exposure prophylaxis; [ ]Yes [ ]No

No valid consent [ ]Yes [ ]No



Children under 2 years of age (i.e. up to their 2nd birthday);	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Administration Details				
Product Name	Batch No	Expiry date (MM/YYYY)	Route of administration (Oral, Left arm, Right arm, etc)	Date & Time

**Premise:**  Pharmacy other via sonar authorisation .....

Name of Pharmacist : ..... Signature : .....