Influenza Vaccination Claim

Reference Number

PATIENT DETAILS

***PPSN**

***Card No.**

***Patient's Name**

Address

***Date of Birth**

***Gender**

TO BE COMPLETED IN WRITING BY PATIENT OR GUARDIAN

1. I verify that I/the named patient have received an injection of Influenza Vaccination.
2. I confirm that I consented to have myself/the named patient vaccinated with Influenza Vaccination.
3. **Data Protection Notice:** Personal data collected by HSE PCRS is used for the purpose of providing a health service. It is required, stored, processed and disclosed to other bodies in accordance with the laws relating to proper treatment of personal data.

Signature (Mandatory)

PRACTITIONER DETAILS

***GMS Number**

***NAME**

The vaccination detailed hereon has been given by me.
*SIGNATURE AND STAMP OF CONTRACTOR

If different from above, then please provide details, in BLOCK CAPITALS, of person administering the vaccine

***Forename:**

***Surname:**

***MCRN:**

***Cold Chain Acc. No.:**

**INCREASED MEDICAL RISK CODES

A ☐	B ☐	C ☐	D ☐
E ☐	F ☐	G ☐	H ☐
I ☐	J ☐	K ☐	L ☐
M ☐	O ☐	P ☐	Q ☐
R ☐	S ☐	T ☐	U ☐
V ☐	W ☐	X ☐	AL ☐

VACCINATION DETAILS

*** Vaccination Date**

DD / MM / YYYY

Batch Number

Name of Vaccine

Manufacturer

Injection Site

Expiry Date

Vacc. Type

* Mandatory fields
** At least one required for payment

Contractors should retain copies of this paperwork for their own records and audit if required.