STRICTLY CONFIDENTIAL *Form 3 – Jan 2011*

VACCINATION STATUS-CONFIRMED MENINGOCOCCAL SEROGROUP C DISEASE

Responsible Centre: Health Protection Agency , Health Protection Services Colindale
Immunisation, Hepatitis and Blood Safety Department, 61 Colindale Avenue, London NW9 5EQ.
Tel: 020 8327 7085 Secure Fax: 020 8327 7404

PLEASE COMPLETE IN BLOCK CAPITAL LETTERS

PART A: Patient Details

Surname: _____ Forename: _____

Reflab no.: _____ D.O.B.: (dd/mm/yyyy) _____/_____/_____

NHS number: _____

PART B: Vaccination History

Has the patient received *Meningitec*, *Menjugate or Neissvac* (Meningococcal C conjugate vaccine [MenC])?

Yes ☐ No ☐ Not known ☐

If yes, please complete immunisation details for all doses below.

	Date administered	Batch no	Vaccine name and/or Manufacturer
1st dose:			
2nd dose:			
3rd dose:			

Has the patient received a dose of Menitorix vaccine (combined MenC-*Haemophilus influenzae type B* [Hib])?

Yes ☐ No ☐ Not known ☐

If yes, please complete immunisation details below.

	Date administered	Batch no
Menitorix vaccine		

For individuals <u>born after July 1999</u> please complete details for all other vaccines administered as part of the primary course in the table overleaf.

PART C: Travel History

Was the patient born in the UK? Yes ☐ No ☐ Not known ☐

If they were not born in the UK when did they move to the UK (mm/yyyy)? _____/_____

Where were they born? _____

Has the patient recently travelled abroad (returning in the last month)? Yes ☐ No ☐ Not known ☐

If yes, where did they recently travel?_____ When did they return? ____/____/_____

Is the patient currently alive? Yes ☐ No ☐ Not known ☐

Completed by: _____ Contact Number: _____ Date: ____/___/_____

Profession: _____ Surgery/clinic name_____

Surgery/ clinic postcode: _____

Thank you for your time and assistance. Please complete both sides of this form.

Please return to the above address or fax to Dr Mary Ramsay on the above number.

For individuals born after July 1999, primary immunisation history, excluding MenC-containing vaccines.

Please complete the following table for all of the specified doses and vaccines that were received in the first two years of life.

Vaccine type	Date administered	Dose (1st, 2nd, 3rd etc.)	Manufacturer/ brand name of vaccine (eg. Pediacel, Infanrix, Act-Hib DTP)	Batch number
Primary (DTaP-Hib-IPV)		1st dose		
Primary (DTaP-Hib-IPV)		2nd dose		
Primary (DTaP-Hib-IPV)		3rd dose		
Pneumococcal vaccine		1st dose		
Pneumococcal vaccine		2nd dose		
Pneumococcal vaccine		3rd dose		
Measles, mumps, rubella vaccine		1st dose		