

Memorandum

Date: 29 March 2021

To: Immunization providers

From: Regional Immunization Team

Re: COVID-19 Vaccination Campaign: Onewrite Documentation

Situation/Background

The VCH COVID-19 Record of Immunization (onewrite form) is currently used for documenting all COVID-19 vaccines administered in VCH. The informed consent section of the onewrite is not currently completed unless informed consent is being provided on the behalf of a minor or from a substitute decision-maker (SDM). However, BCCDC requires documentation of informed consent per Appendix A in the BCCDC Immunization Manual. The Ministry of Health is requiring informed consent be documented in the Provincial eForm. Data entry into the Provincial eForm is done by administrative support (not the immunization provider); when the informed consent box is not marked, it is not documented as the transcriber cannot document on the clinician’s behalf if consent box is not marked.


Action

- Ensure all sections of the One-Write are completed.
- Tick the *informed consent* tick box to indicate verbal informed consent was obtained.
- When consent is given by a Substitute Decision Maker or Parent/Guardian, document their name and relationship to client. If they are present, obtain their written signature.
- Ensure all demographic information (address, phone number, etc) is documented to assist in correctly identifying the client.

Keep in a safe place **RECORD OF COVID-19 IMMUNIZATION** Keep in a safe place

Date	Name: Last, First	Care Card #	Birthdate (dd/mm/yyyy)	Sex													
<p>COMMON COVID-19 SIDE EFFECTS CAN INCLUDE:</p> <p><input type="checkbox"/> Very common: pain at injection site, tiredness, headaches, muscle pain, chills, joint pain, fever.</p> <p><input type="checkbox"/> Uncommon: enlarged lymph nodes.</p> <p><input type="checkbox"/> With any vaccine or drug, there is a very rare chance of a severe allergic reaction. Get medical help right away if you experience trouble breathing, hives, or generalized swelling.</p> <p>For any serious or unexpected reactions please inform your healthcare provider.</p>		Address		Phone #													
		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Trade Name</th> <th>Dose #</th> <th>Lot #</th> <th>Site</th> <th>Provider Signature</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Pfizer <input type="checkbox"/> COVISHIELD (SII) Other: _____</td> <td></td> <td></td> <td>R <input type="checkbox"/> L <input type="checkbox"/></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Moderna <input type="checkbox"/> AstraZeneca <input type="checkbox"/> _____</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Trade Name	Dose #	Lot #	Site	Provider Signature	<input type="checkbox"/> Pfizer <input type="checkbox"/> COVISHIELD (SII) Other: _____			R <input type="checkbox"/> L <input type="checkbox"/>		<input type="checkbox"/> Moderna <input type="checkbox"/> AstraZeneca <input type="checkbox"/> _____				
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<p><input checked="" type="checkbox"/> Informed consent</p> <p>Signature _____ For minor children and adults unable to self-consent Print name and relationship to client _____</p> <p><input type="checkbox"/> COVID-19 vaccine #2 in _____ weeks. Date _____</p>																	

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