

## Human Papilloma Virus (HPV) Monthly Claim & Monitoring Form

Practice Name:  
Practice Telephone Number:  
Contact name:  
Month of Claim:

Number of doses at month start	
Number of doses received this month	
Number of doses wasted this month	
Number of doses in stock at month end	
Total doses used in session	

Total number of females in cohort:

	Patient Number	Date of Birth	Date of 1 <sup>st</sup> Dose	Date of 2 <sup>nd</sup> Dose	Date of 3 <sup>rd</sup> Dose
			(Just complete relevant dose date)		
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
	Total	---			

Please return form to your Primary Care Manger no later than the 7<sup>th</sup> working day following the month end claimed.

Appendix 2

	Patient Number	Date of Birth	Date of 1 <sup>st</sup> Dose	Date of 2 <sup>nd</sup> Dose (Just complete relevant dose date)	Date of 3 <sup>rd</sup> Dose
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					
26.					
27.					
28.					
29.					
30.					
	<b>Total</b>	- - -			

Please indicate the number of patients refusing the HPV vaccination this month in the appropriate reason box:

	Disagree with Immunisations		Insufficient Information		Perceived Side Effects		Total DNA
	Religious / Cultural		Contraindications		Other		Total Refused

**Declaration**

**I certify that the above claim is made in accordance with the PCT's LES for HPV Vaccinations Service Specification and that all claims are fully supported by the relevant audit trails within the practice.**

**I hereby agree that if required, this information will be made available to the PCT/Audit if requested to do so.**

**Date:**

**Signed:** \_\_\_\_\_

Please return form to your Primary Care Manger no later than the 7<sup>th</sup> working day following the month end claimed.