**Vaccine Order Form – Community Pharmacies**

**Pharmacy Name and Address:**

**Date and Time Order Required (please give 2 weeks for delivery):**

**Ordered by:**

**Designation:**

**Date:**

**Contact Number:**

|  |  |
| --- | --- |
| **VACCINES** | **Amount of Doses Required****(multiples of 10)** |
| **(AGE 18‑64) Cell-based Quadrivalent Influenza Vaccine (QIVc)**10 Pre‑Filled Syringe Pack |  |
| **(AGE 65 PLUS) Adjuvanted Quadrivalent Influenza Vaccine (aQIV)**10 Pre‑Filled Syringe Pack |  |
| **(AGE 2-18)**  **Live Attenuated Intranasal Influenza Vaccine (LAIV) Fluenz**10 Pre‑Filled Syringe Pack |  |
| **(AGE 12 PLUS) Comirnaty Original/Bivalent BA.4-5 COVID-19 Vaccine**10 Vial Pack |  |

**For Pharmacy use:**

**Issued by:**

**Picked by:**

**Checked by:**

**Please email all orders to:** **FV.vaccineservice@nhs.scot**

**Vaccine Holding Centre Contact Telephone Number: 01324 616112 (Emergencies only)**