FULL Name:	
Medicare number:	
Date of birth:	
Address:	
Phone contact number:	
Email address:	

Yes	No	PFIZER COVID vaccine available
☐	☐	Have you had an allergic reaction to a previous dose of a COVID-19 vaccine?
☐	☐	Have you had anaphylaxis to another vaccine or medication?
☐	☐	Have you had a serious adverse event, that following expert review by an experienced immunisation provider or medical specialist was attributed to a previous dose of COVID-19 vaccine (and did not have another cause identified)?
☐	☐	Have you ever had mastocytosis (a mast cell disorder) which has caused recurrent anaphylaxis?
☐	☐	Have you had COVID-19 before?
☐	☐	Do you have a bleeding disorder?
☐	☐	Do you take any medicine to thin your blood (an anticoagulant therapy)?
☐	☐	Do you have a weakened immune system (immunocompromised)?
☐	☐	Are you pregnant? # Pfizer and Moderna are the preferred vaccines for pregnant women. If these vaccines are not available, Novavax can be considered. For more information, see: www.health.gov.au/initiatives-and-programs/covid-19-vaccines/who-can-get-vaccinated/pregnant-women
☐	☐	Have you been sick with a cough, sore throat, fever or are feeling sick at the moment?

Yes	No	PFIZER COVID vaccine available
☐	☐	Have you had a COVID-19 vaccination before?
☐	☐	Have you received any other vaccination in the last 7 days?
☐	☐	Have you been diagnosed with myocarditis and/or pericarditis after a previous COVID-19 vaccine dose? ^
☐	☐	Have you had myocarditis or pericarditis within the past three months? ^
☐	☐	Do you currently have acute rheumatic fever or acute rheumatic heart disease? ^
☐	☐	Do you have severe heart failure? ^
☐	☐	Have you ever been diagnosed with capillary leak syndrome? ^

^If you answered yes to any of these questions, you should talk to your immunisation provider about which vaccine is best for you, and to consider whether any additional precautions are needed. For more information, see: www.health.gov.au/resources/publications/covid-19-vaccination-guidance-on-myocarditis-and-pericarditis-after-mrna-covid-19-vaccines

Consent to receive COVID-19 vaccine (or patient's parent, guardian or substitute decision-maker)

☐ I confirm I have received and understood information provided to me on COVID-19 vaccination.

☐ I confirm that I have none of the above conditions apply to me, or I have discussed these conditions and any other special circumstances with my regular health care provider and/or vaccination provider.

☐ I agree to receive a course of COVID-19 vaccine / I agree to receive a booster of
COVID-19 vaccine

Signature:		Date: