HOLLAND PARK
FAMILY MEDICAL PRACTICE

Welcome to Holland Park Family Medical Practice. We need this information to provide the best quality care. This form complies with the RACGP Standards for general practices. This means your personal health information is kept private and secure, as required by federal and state privacy laws. Please complete all sections and read the Personal & Health Information Consent section at the end of the form.

Title:	Surname:	First Name:		Middle Name:
	Preferred Name:			Date of Birth: / /
Gender:	☐ Male ☐ Female ☐ Other			
Marital Status:	☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed			
Street Address:				
	Suburb:			Post Code:
Phone Number:	Home:	Mobile:		Work:
E-mail address:				
Best method of contact	☐ Home Phone ☐ Mobile ☐ Mail ☐ Email			
For Health Initiatives – are you Aboriginal/Torres Strait Islander?	☐ NO ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander			
Medicare Number:		Ref:		Expiry:
DVA Number:		☐ Gold ☐ White		Expiry:
Pension Card Number:				Expiry:
Next of Kin:	Name:	Relationship:		Phone No:
Emergency Contact:	Name:	Relationship:		Phone No:

Do you have or have you had a history of the following? (please elaborate)		
☐ Diabetes	☐ Other	
☐ Asthma	☐ Hypertension	
ALLERGIES/SENSITIVITIES	**IMMUNISATIONS**	
Do you have any allergies or are you sensitive to drugs or dressings?	☐ Influenza Date	☐ Pfizer COVID /Astrazeneca Date

How is the information you provide at your appointment used

For information on how your personal details are collected, stored and used visit https://www.health.gov.au/covid19-vaccines

On the day you receive your vaccine

Before you get vaccinated, tell the person giving you the vaccination if you:

- Have any allergies, particularly anaphylaxis (a severe allergic reaction). An allergy is when you come near or in contact with something and your body reacts to it and you get sick very quickly. This may include things like an itchy rash, your tongue getting bigger, your breathing getting faster, you wheeze or your heart beating faster.
- If you have an Epi Pen or have had one before.

- If you are immunocompromised. This means that you have a weakened immune system that may make it harder for you to fight infections and other diseases. Sometimes a disease like diabetes or cancer can cause this or certain medicines or treatments you take, such as medicine for cancer.

Yes	No	
☐	☐	Do you have any serious allergies, particularly anaphylaxis, to anything, or carry or have been
☐	☐	Have you had an allergic reaction after being vaccinated before?
☐	☐	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 (having a baby) or think you might be pregnant?
☐	☐	Are you planning to get pregnant?
☐	☐	Are you breastfeeding?
☐	☐	Have you been sick with a cough, sore throat, fever or are feeling sick in another way?
☐	☐	Have you had a COVID-19 vaccination before?
☐	☐	Have received any other vaccination in the last 14 days?

Please talk to your doctor if you have any questions or concerns before getting your COVID-19 vaccination.

Consent to receive COVID-19 vaccine

□ I confirm I have received and understood information provided to me on COVID-19 vaccination
□ I confirm that none of the conditions above apply, or I have discussed these and/or any other special circumstances with my regular health care provider and/or vaccination service provider
□ I agree to receive a course of COVID-19 vaccine (two doses of the same vaccine)
□ I consent to being contacted by Ph/sms/email for clinical/covid/appt reminders
□ I understand that I do not register as a patient with Holland Park Family Medical Practice
Patient's signature: _____Patient's name: _____
Date:
□ I am the patient's legal guardian or legal substitute decision-maker, and agree to COVID-19 vaccination of the patient named above Legal guardian/substitute decision-maker's name:
Signature: _____Date:

For provider use:

DOSE 1:	DOSE 2
Date vaccine administered:	Date vaccine administered:
Time received:	Time received:
COVID-19 vaccine brand administered:	COVID-19 vaccine brand administered:
Batch no:	Batch no:
Serial no:	Serial no:
Site of vaccine injection:	Site of vaccine injection:
Name of vaccination service provider:	**Name of vaccination service provider:**