



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.

**About COVID-19 vaccination:** People who have a COVID-19 vaccination have a much lower chance of getting sick from COVID-19. There are 2 brands of vaccine in use in Australia. Both are effective and safe. Comirnaty(Pfizer) vaccine is preferred to COVID-19 Vaccine AstraZeneca for adults under 60 years. Tell your healthcare provider if you have any side effects after vaccination that you are worried about. You may be contacted by SMS at 3, 8 and 42 days after receiving the vaccine to see how you are feeling. Some people may still get COVID-19 after the vaccination. Still follow public health precautions including - social distancing; washing hands, wearing a mask. stay home if you are unwell with cold or flu-like symptoms, and arrange to get a COVID-19 test.

Medical experts have studied COVID-19 vaccines to make sure they are safe. Most side effects are mild. They may start on the day of vaccination and last for around 1-2 days. As with any vaccine or medicine, there may be rare and/or unknown side effects. A very rare side effect of blood clotting (thrombosis) with low blood platelet levels (thrombocytopenia) has been reported following vaccination with the COVID-19 Vaccine AstraZeneca. This is not seen after Comirnaty (Pfizer) vaccine. For further information on the risk of this rare condition refer to the [Patient information sheet on AstraZeneca COVID-19 vaccine and thrombosis with thrombocytopenia syndrome \(TTS\)](#).

Title:	Surname:	First Name:	Middle Name:
	Preferred Name:	Date of Birth: / /	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Defacto <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		
Street Address:			
	Suburb:	Post Code:	
Phone Number:	Mobile:	Home:	Other:
E-mail address:			
For Health Initiatives – are you Aboriginal/Torres Strait Islander?	<input type="checkbox"/> NO <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Aboriginal & Torres Strait Islander		
Medicare Number:	Ref:	Expiry:	
DVA:	<input type="checkbox"/> Gold <input type="checkbox"/> White		
Pension Card Number	Ref:	Expiry:	
Emergency Contact/NOK:	Name:	Relationship:	Phone No:
Do you have or have you had a history of any of the following	<input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma		<input type="checkbox"/> Hypertension <input type="checkbox"/> Other
<b>Immunizations</b>	<input type="checkbox"/> Influenza Date		<input type="checkbox"/> Pfizer/AstraZeneca Date

#### How is the information you provide at your appointment used.

Vaccination providers record all vaccinations on the Australian Immunisation Register, as required by Australian law. You can view your vaccination record online through your: Medicare account; MyGov account; MyHealthRecord account. For information on how your personal details are collected, stored and used visit <https://www.health.gov.au/using-our-websites/privacy/privacy-notice-for-covid-19-vaccinations>

#### On the day you receive your vaccine

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

- Have had an allergic reaction, particularly anaphylaxis (a severe allergic reaction) to a previous dose of a COVID-19 vaccine, to an ingredient of a COVID-19 vaccine, or to other vaccines or medications.
- 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. You can still have a COVID vaccine, but you may wish to consider the best timing of vaccination depending on your underlying condition and/or treatment.

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Have you had an allergic reaction to a previous does of a COVID-19 vaccine?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had anaphylaxis to another vaccine or medication?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a mast cell disorder?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had COVID-19 before?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a bleeding disorder?
<input type="checkbox"/>	<input type="checkbox"/>	Do you take any medicine to thin your blood(an anticoagulant therapy)?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a weakened immune system (immunocompromised)?
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant(having a baby) of do you think you might be pregnant?*
<input type="checkbox"/>	<input type="checkbox"/>	Have you been sick with a cough, sore throat, fever or are feeling sick in another way?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had a COVID-19 vaccination?
<input type="checkbox"/>	<input type="checkbox"/>	Have you received any other vaccination in the last 7 days?

**Relevant only for those receiving Vaxzevria (AstraZeneca) :**

<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed with capillary leak syndrome?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had major venous and/or arterial thrombosis in combination with thrombocytopenia, including diagnosed Thrombotic Thrombocytopenic Syndrome (TTS), following a previous dose of a COVID-19 vaccine? *
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had cerebral venous sinus thrombosis?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had heparin-induced thrombocytopenia? *
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had blood clots in the abdominal veins (splanchnic veins)? *
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had antiphospholipid syndrome associated with blood clots? *
<input type="checkbox"/>	<input type="checkbox"/>	Are you under 60 years of age? *

**Relevant only for those receiving Comirnaty (Pfizer):**

<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had myocarditis or pericarditis?
<input type="checkbox"/>	<input type="checkbox"/>	Do you currently have, or have you recently had acute rheumatic fever or endocarditis?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have congenital heart disease?
<input type="checkbox"/>	<input type="checkbox"/>	For people under 30 years of age: do you have dilated cardiomyopathy?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have severe heart failure?
<input type="checkbox"/>	<input type="checkbox"/>	Are you a recipient of a heart transplant?

\* Comirnaty is the preferred vaccine for people in these groups but if not available, AstraZeneca COVID-19 vaccine can be considered if the benefits of vaccination outweigh the risk. For more information refer to the: [Patient information sheet on thrombosis with thrombocytopenia syndrome \(TTS\)](#)

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

Patient's signature: \_\_\_\_\_ Patient's name: \_\_\_\_\_, Date: / /2021

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-makers name:

Signature: \_\_\_\_\_ Date: / /2021