Quinns Mindarie
SUPER CLINIC

Consent Form for COVID-19 Vaccination

Before you get vaccinated, please 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.
- 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-19 vaccine, but may wish to consider the best timing of vaccination depending on your underlying condition and /or treatment.

Please answer the below questions:	Yes	No
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 was attributed to a previous dose of a COVID-19 vaccine?		
Have you had COVID-19 before?		
Have you ever had mastocytosis which has caused recurrent anaphylaxis?		
Do you have a bleeding disorder?		
Do you take any medicine to thin your blood (anticoagulant therapy)?		
Do you have a weakened immune system (immunocompromised)?		
Are you pregnant? *		
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 you received any other vaccination in the last 7 days?		
Do you consent to Smartvax sending an SMS message in 3 days to monitor for any reaction to the vaccination/s?		
RELEVANT FOR ASTRAZENECA COVID-19 VACCINE ONLY		
Have you ever been diagnosed with capillary leak syndrome?		
Have you ever had a major venous and/or arterial thrombosis in combination with thrombocytopenia, including diagnosed Thrombotic Thrombocytopenia Syndrome (TTS), following a previous dose of COVID-19 vaccine?		
Have you ever had cerebral venous sinus thrombosis (a type of brain clot)? *		
Have you ever had heparin-induced thrombocytopenia (a rare reaction to heparin treatment) *		
Have you ever had blood clots in the abdominal veins? (splanchnic veins) *		
Have you ever had anti-phospholipid syndrome associated with blood clots? *		
Are you under 60 years of age? *		

**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.*

RELEVANT ONLY FOR THOSE RECEIVING COMIRNATY (PFIZER COVID-19 VACCINATION)		
	YES	NO
Have you ever had myocarditis or pericarditis?		
Do you currently have, or have you recently had acute rheumatic fever or endocarditis?		
For people under 30 years of age: do you have dilated cardiomyopathy?		
Do you have severe heart failure?		
Are you a recipient of a heart transplant?		

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

Created: 12/03/2021 HD Updated: 10/08/2021 HD Updated 31/08/2021

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Patient Information:

Name:	
Medicare Number:	
Date of Birth:	
Address:	
Phone Contact Number:	
e-mail:	
Gender:	

Language spoken at home:	
Country of birth:	

Are you Aboriginal and/or Torres Strait Islander?

☐ Yes, Aboriginal only ☐ Yes, Torres Strait Islander only

☐ Yes Aboriginal & Torres Strait islander ☐ No ☐ Prefer not to answer

Next of kin (in case of emergency)	
Name:	
Phone Contact Number:	

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)**

Patients Name:	
Patients Signature:	
Date:	

☐ **I am the patient's guardian or substitute decision-maker, and agree to COVID-19 vaccination of the patient named above**

Guardian/substitute decision-maker's name:	
Guardian/substitute decision maker's signature	
Date:	