Consent Checklist

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 ever had mastocytosis 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?*
☐	☐	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?

Relevant only for those receiving AstraZeneca COVID-19 vaccine:

☐	☐	Have you ever been diagnosed with capillary leak syndrome?
☐	☐	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?
☐	☐	Have you ever had cerebral venous sinus thrombosis? *
☐	☐	Have you ever had heparin-induced thrombocytopenia? *
☐	☐	Have you ever had blood clots in the abdominal veins (splanchnic veins)? *
☐	☐	Have you ever had antiphospholipid 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. For more information refer to the: Patient information sheet on thrombosis with thrombocytopenia syndrome (TTS)

Relevant only for those receiving Comirnaty: (pfizer)

☐	☐	Have you ever had myocarditis or pericarditis?
☐	☐	Do you currently have, or have you recently had acute rheumatic fever or endocarditis?
☐	☐	Do you have congenital heart disease?
☐	☐	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?

Last updated: 30 July 2021

Patient information

Name:	
Medicare number:	
Individual Health Identifier (IHI) if applicable:	
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 and 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)

Patient's name:	
Patient's signature:	
Date:	