Priceline Pharmacy Glenorchy

346 Main Road
Genorchy
TAS 7010
Phone: 0362727138
Email:
pricelinehobartnursinghome@gmail.com

Pre-Immunisation Screening and Consent

Consumer Details

Name: *

Mobile Number:

Email:

Address: *

Allergies: *

Date of Birth: *

Medicare Number: *

Medicare Expiry Date: *

* items are required. Mobile phone numer and email are optional

Primary Healthcare Provider

Name:

Address:

Phone:

Email:

Health and Suitability for COVID-19 Vaccination

Please tell your nurse, doctor or pharmacist if you answer **yes** to any of the following statements as vaccination may not be suitable for you today.

☐ Yes ☐ No Have you had an allergic reaction to a previous dose of a COVID-19 vaccine?

☐ Yes ☐ No Have you had anaphylaxis to another vaccine or medication?

☐ Yes ☐ No 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 a COVID-19 vaccine (and did not have another cause identified)?

☐ Yes ☐ No Have you ever had mastocytosis (a mast cell disorder) which has caused recurrent anaphylaxis?

☐ Yes ☐ No Have you had COVID-19 before?

☐ Yes ☐ No Do you have a bleeding disorder?

☐ Yes ☐ No Do you take medicine to thin your blood (anticoagulant therapy)?

☐ Yes ☐ No Do you have a weakened immune system (immunocompromised)?

☐ Yes ☐ No Are you pregnant? *

☐ Yes ☐ No Have you been sick with a cough, sore throat, fever or are feeling sick in another way?

☐ Yes ☐ No Have you had a COVID-19 vaccination before?

☐ Yes ☐ No Have you received any other vaccination in the last 7 days?

☐ Yes ☐ No Are you Aboriginal and/or Torres Strait Islander?

Relevant only for those receiving AstraZeneca Vaxzevria:

☐ Yes ☐ No Have you ever been diagnosed with capillary leak syndrome?

☐ Yes ☐ No Have had thrombosis (clotting) together with thrombocytopenia (low platelets) within 42 days after having a previous dose of AstraZeneca?

☐ Yes ☐ No Have you ever had cerebral venous sinus thrombosis? *

☐ Yes ☐ No Have you ever had heparin-induced thrombocytopenia? *

☐ Yes ☐ No Have you ever had blood clots in the abdominal veins (splanchnic veins)? *

☐ Yes ☐ No Have you ever had antiphospholipid syndrome associated with blood clots? *

☐ Yes ☐ No Are you under 60 years of age? *

* Pfizer or Moderna are the preferred vaccines for people in these groups. If these vaccines are not available, AstraZeneca can be considered if the benefits of vaccination outweigh the risks.

For more information, see Patient information sheet on thrombosis with thrombocytopenia syndrome (TTS)

If you are pregnant, see Decision guide to COVID-19 vaccinations for women who are pregnant, breastfeeding or planning pregnancy

Relevant only for those receiving Pfizer or Moderna:

☐ Yes ☐ No Have you been diagnosed with myocarditis and/or pericarditis that is attributed to a previous dose of Pfizer or Moderna?

☐ Yes ☐ No Have you had myocarditis, pericarditis or endocarditis within the past six months?

☐ Yes ☐ No Do you currently have acute rheumatic fever or acute rheumatic heart disease?

☐ Yes ☐ No Do you have severe heart failure?

Notes

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.
• 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.

Consent

• I have received and understood information provided on the 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 request to have this vaccine and understand that it is completely voluntary.

☐ I would like a record of my vaccination, available through the pharmacy App. You will receive a text message with registration link. Please confirm your mobile number: _____

Name of patient (or parent/guardian of child): _____

Signature of patient (or parent/guardian of child): _____

Date: _____