baywest medical centre™

Wynnum West Shopping Centre
Cnr Randall & Wynnum Roads
Wynnum West Qld 4178

Phone: 07 3396 5309
Fax: 07 3396 2538

Patient Details:

Name: _____ **Medicare:** _____

D.O.B.: ____/_____/_____ Ref: ____ Exp: _____/_____

Address:_____ **Phone: M:** _____ **H:** _____

_____ **Email:** _____

Next of Kin:

Name: _____ **Phone:**_____

Please carefully read and answer the below questions:

Y	N		Y	N	
		Do you suffer from an anaphylactic allergic reaction?			Do you have a bleeding disorder?
		Have you had an allergic reaction after being vaccinated before?			Do you take any blood thinning medications?
		Do you have a mast cell disorder?			Have you been sick with a cough, sore throat, fever or are feeling sick in another way?
		Have you had COVID-19 before?			Have you received any other vaccination in the last 7 days?
		Are you pregnant, or do you think you might be pregnant?			Have you had a COVID-19 vaccination before?
		Do you have a history of Heparin Induced Thrombocytopaenia (HITs)?			Do you have a history of Cerbral Venous Sinus Thrombosis?
		Have you ever had blood clots in the abdominal veins?			Have you ever had antiophospholipid syndrome associated with blood clots?

Common reactions to vaccination include:

- Pain, redness and/or swelling at the injection site
- Headache
- Muscle/Joint pain
- Mild fever
- Tiredness
- Nausea

Serious reactions such as allergic reactions are extremely rare. They usually occur within 15 minutes of receiving a vaccine. After you receive your vaccine, you should wait this amount of time before you leave to ensure your safety in case a reaction occurs.

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 12 weeks apart).
☐	I agree to have my health care provider upload my vaccination to the Australian Immunisation Register as required by Australian law.

Patient Full Name: _____

Patient Signature: _____ Date: ____/____/_____