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 breastfeeding, or do you think you might be pregnant?			Have you had a COVID-19 vaccination before?
		Do you have any precautionary heart conditions? *(if yes, you will be required to provide written proof of the discussion with you Cardiologist/GP)*			Are you immunocompromised?

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 Pfizer 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 3 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: ____/____/______