

THIRD PRIMARY DOSE COVID-19 VACCINATION CONSENT AND DECLARATION FORM



Third dose appointment details:

Appointment date	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (Day / Month / Year)	Appointment time	<input type="text"/>
Appointment location	<input type="text"/>		

Demographics:

Given name <i>(as registered with Medicare)</i>	<input type="text"/>	Middle initial	<input type="text"/>	Family name	<input type="text"/>
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown				
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (Day / Month / Year)				
Indigenous status	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Aboriginal & Torres Strait Islander <input type="checkbox"/> Neither				
Country of birth	<input type="text"/>				

Contact details:

Residential address <i>(as registered with Medicare)</i>	<input type="text"/>
Mobile number	<input type="text"/>
Email address	<input type="text"/>

Medicare details:

Residence status	<input type="checkbox"/> Eligible Australia resident <input type="checkbox"/> Ineligible overseas resident <input type="checkbox"/> Reciprocal overseas resident <input type="checkbox"/> Unknown				
Medicare number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>	Position on card (IRN)	<input type="text"/>	Expiry date:	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>

Person to contact/Next of kin:

Full name	<input type="text"/>
Phone number	<input type="text"/>

Patient COVID-19 vaccination history

Which vaccine did you previously receive for second dose?
 AstraZeneca (Vaxzevria) Moderna (Spikevax)
 Pfizer (Comirnaty) Other _____

Date of second dose: / /

Note: Australian Technical Advisory Group on Immunisation (ATAGI) recommends individuals receive the 3rd COVID-19 dose between 2-6 months after 2nd dose.

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Consent: Tick your answer in the box on the right	Yes	No
Have you had an allergic reaction to a previous dose of a COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had anaphylaxis to another vaccine or medication?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had COVID-19 before? <i>If yes, please consult your Health Professional before receiving 3rd dose vaccination</i>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take any medicine to thin your blood (an anticoagulant therapy)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a weakened immune system (immunocompromised)?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant? *	<input type="checkbox"/>	<input type="checkbox"/>
Have you been sick with a cough, sore throat, fever or are feeling sick in another way?	<input type="checkbox"/>	<input type="checkbox"/>
Have you received any other vaccination in the last 7 days?	<input type="checkbox"/>	<input type="checkbox"/>

Relevant only for those receiving AstraZeneca (Vaxzevria): Tick your answer in the box on the right	Yes	No
Do you have any severe allergies, particularly anaphylaxis (to anything including Polysorbate 80)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had mastocytosis (a mast cell disorder) which has caused recurrent anaphylaxis?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with capillary leak syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had thrombosis (clotting) together with thrombocytopenia (low platelets) within 42 days after having a previous dose of AstraZeneca (Vaxzevria) COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had cerebral venous sinus thrombosis? *	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had heparin-induced thrombocytopenia? *	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had blood clots in the abdominal veins (splanchnic veins)? *	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had antiphospholipid syndrome associated with blood clots? *	<input type="checkbox"/>	<input type="checkbox"/>
Are you under 60 years of age? *	<input type="checkbox"/>	<input type="checkbox"/>

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

Relevant only for those receiving Pfizer (Comirnaty) or Moderna (Spikevax): Tick your answer in the box on the right	Yes	No
Do you have any severe allergies, particularly anaphylaxis (to anything including polyethylene glycol)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with myocarditis and/or pericarditis that is attributed to a previous dose of Pfizer (Comirnaty) or Moderna (Spikevax) COVID-19 vaccines?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had myocarditis, pericarditis or endocarditis within the past six months?	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently have acute rheumatic fever or acute rheumatic heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have severe heart failure?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered Yes to any of the above questions, you may still be able to receive Pfizer (Comirnaty) or Moderna (Spikevax), however you should talk to your GP, immunisation specialist or cardiologist first to discuss the best timing of vaccination and whether any additional precautions are needed.

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Declaration:

- I confirm that I am severely immunocompromised and have a condition and/or therapy for which a third primary COVID-19 vaccination dose is recommended as per ATAGI <https://www.health.gov.au/resources/publications/atagi-recommendations-on-the-use-of-a-third-primary-dose-of-covid-19-vaccine-in-individuals-who-are-severely-immunocompromised>
- I have received the information provided to me in the Australian Government COVID-19 vaccination *(select appropriate COVID-19 vaccine below)*
- Information on Pfizer (Comirnaty) COVID-19 vaccine**
 - Information on Moderna (Spikevax) COVID-19 vaccine**
 - Information on AstraZeneca (Vaxzevria) COVID-19 Vaccine**
- and have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions. Please refer to the Australian Government COVID-19 vaccination patient resources <https://www.health.gov.au/resources/collections/covid-19-vaccination-patient-resources>
- I consent to receive a third dose of COVID-19 Vaccine

Patient's name		
Patient's signature	Print and Sign	Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (Day/Month/Year)

Use and Disclosure of Information

Information collected as part of this process will be subject to the same use and disclosure rules as other health information collected by the NSW Public Health System. Please refer to the NSW Health Privacy Leaflet for Patients <https://www.health.nsw.gov.au/patients/privacy/Pages/privacy-leaflet-for-patients.aspx>

Your personal and health information may be used and disclosed for purposes connected with the roll-out of the COVID-19 vaccine program, including sharing your information with the Australian Government and for surveillance, assessment and monitoring of the COVID-19 vaccine or vaccination program.

Your personal information held in NSW Health's database such as name, phone number and email address may be used to contact you following your vaccination for monitoring purposes. You may receive an SMS message or an email in the days following your vaccination and further direct follow-up by NSW Health staff.

If you are being offered vaccination on the basis of the type of work that you do, your employer may be contacted about your vaccination dates so that they can appropriately schedule staff at the workplace.

PROVIDER USE ONLY

Medication administration

Vaccination administration details	
COVID-19 vaccine brand name	<input type="checkbox"/> Pfizer (Comirnaty) <input type="checkbox"/> Moderna (Spikevax) <input type="checkbox"/> AstraZeneca (Vaxzevria)
Dose administered	<input type="checkbox"/> Third dose Dosage in mL: _____
Product label	Vial supply lot: _____ Vial serial number: _____ Vaccine expiry date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (Day/Month/Year)

Injection site: <input type="checkbox"/> Right arm <input type="checkbox"/> Left arm <input type="checkbox"/> Other	Observation time: <input type="checkbox"/> 15 minutes <input type="checkbox"/> 30 minutes
Date administered: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (Day/Month/Year)	Time administered:
Name	
Designation	
Signature	Print and Sign
	Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (Day/Month/Year) Time:

Note: Adverse reaction Adverse event information must be recorded in the electronic medical record or paper Adverse Event Following Immunisation (AEFI) form.