

COVID Consent and Checklist Form

This form is only to be used by patients who have booked a Covid-19 Vaccination at Conrad Road Family Practice

Patient Information

Full Name:		D.O.B	
I am receiving: <i>Please Circle One</i>	Pfizer (12 years plus)	Pfizer (5 to 11 years)	Moderna (Booster ONLY)
This is the: <i>Please Circle One</i>	Booster	1 st Dose	2 nd Dose
			3 rd Dose (immune deficient)

COVID Checklist Response

1. Have you had an allergic reaction to a previous dose of a COVID-19 vaccine?	Yes/No	13. Have you ever been diagnosed with capillary leak syndrome?	Yes/No
2. Have you had anaphylaxis to another vaccine or medication?	Yes/No	14. 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?	Yes/No
3. Have you had a serious adverse event, that following expert review was attributed to a previous dose of a COVID-19 vaccine?	Yes/No	15. Have you ever had cerebral venous sinus thrombosis?	Yes/No
4. Have you ever had mast cell disorder?	Yes/No	16. Have you ever had heparin-induced thrombocytopenia?	Yes/No
5. Have you had COVID-19 before?	Yes/No	17. Have you ever had blood clots in the abdominal veins (splanchnic veins)?	Yes/No
6. Do you have a bleeding disorder?	Yes/No	18. Have you ever had antiphospholipid syndrome associated with blood clots?	Yes/No
7. Do you take any medicine to thin your blood (an anticoagulant therapy)?	Yes/No	19. Are you under 60 years of age?	Yes/No
8. Do you have a weakened immune system (immunocompromised)?	Yes/No	20. Have you ever had myocarditis or pericarditis?	Yes/No
9. Are you pregnant?	Yes/No	21. Do you currently have, or have you recently had acute rheumatic fever or endocarditis?	Yes/No
10. Do you currently have or recently had a cough, sore throat, fever or are feeling sick in another way?	Yes/No	22. Do you have congenital heart disease?	Yes/No
11. Have you had a COVID-19 vaccination before?	Yes/No	23. Do you have dilated cardiomyopathy?	Yes/No
12. Have you received any other vaccination in the last 7 days?	Yes/No	24. Do you have heart failure?	Yes/No

CONSENT Response

26. I confirm I have received and understood information provided to me on COVID-19 vaccination.	Yes/No
27. (a) I agree to receive a course of COVID-19 vaccine; OR (b) I am the patient's legal guardian or legal substitute decision-maker and agree to COVID-19 vaccination of the patient named above.	Yes/No

Patient Name:

Please print your name

Signature:

Date:

If not patient signing,
your name:

Relationship
to patient:

Please print your name

Please email completed form to: sooriyamedical.reception@gmail.com