Conrad Road Family Practice

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COVID Consent and Checklist Form

Patient Information

Full Name:		**D.O.B**	

I am receiving: *Please circle one*	Pfizer (Adult / 12 years plus)	Moderna (Booster ONLY)

This is the: *Please circle one*	Booster	1st Dose	2nd Dose	3rd 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 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

Please refer to our website for information regarding vaccinations and potential side effects. I confirm I have received and understood information provided to me on COVID-19 vaccination.	Yes/No
(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 Signature: _____

Please print your name

Signature: _____ Date: _____

If not patient signing, your name: _____

Please print your name

Relationship to patient: _____

Please email the completed form by no later than the day before your appointment to:
sooriyamedical.reception@gmail.com