**You will receive a phone call from us to book your appointment within 3-5 business days of you returning your form.**

**Patient Information:**

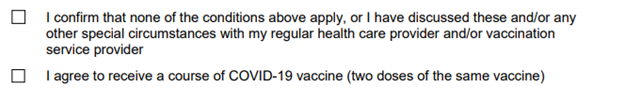
|  |  |
| --- | --- |
| Name: |  |
| Medicare Number: |  |
| Date of Birth: |  |
| Address: |  |
| Contact Number: | Mobile:  Home: |
| Email: |  |
| Gender: |  |
| Eligibility Criteria –  **Please circle** | * Age 60 or over * Chronic Medical Condition – please provide further detail   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Critical Worker – please provide further detail   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please note you may need to provide proof of your eligibility in the form of ID showing your date of birth or medical correspondence showing evidence of your health condition.**

**Please answer the following *(continues on the next page)***

|  |  |  |
| --- | --- | --- |
| **YES** | **NO** |  |
|  |  | Do you have any serious allergies, particularly anaphylaxis, to anything? |
|  |  | Have you had an allergic reaction after being vaccinated before? |
|  |  | Do you have a mast cell disorder? |
|  |  | Have you had COVID-19 before? |
|  |  | Do you have a bleeding disorder? |
|  |  | Do you take any Warfarin to thin your blood? (An anticoagulant therapy)? |
|  |  | Do you have a weakened immune system? (Immunocompromised)? |
|  |  | Are you pregnant or do you think you might be pregnant? |
|  |  | Are you breastfeeding? |
|  |  | Have you been sick with a cough, sore throat, fever or are feeling sick in another way? |
|  |  | Have you had a COVID-19 Vaccination before? |
|  |  | Have you received any other vaccination in the last 14 days? |
|  |  | Do you have a history of Cerebral Venous Sinus Thrombosis or Heparin induced Thrombocytopenia? |

**If you have answered YES to any of the above you may need to consult with one of our doctors prior to booking for the COVID-19 vaccine. Please return this form to Andrew Place Clinic ASAP. You will then be contacted by one of our staff to make an appointment for your vaccine.**

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**Consent to receive COVID-19 vaccine**

|  |  |
| --- | --- |
| **Patients Name:** |  |
| **Signature:** |  |
| **Date:** |  |

**PLEASE RETURN YOUR FORM TO:** [**covidvaccines@andrewplaceclinic.com.au**](mailto:covidvaccines@andrewplaceclinic.com.au)