RECOMMENDATION TO RECEIVE THE PFIZER (COMIRNATY™) COVID-19 VACCINE

Family name	
Given name	
Date of birth	☐☐ / ☐☐ / ☐☐☐☐
Sex:	☐ Male ☐ Female ☐ Other
Contact number	
Home address	
Medicare number	☐☐☐☐ - ☐☐☐☐☐ - ☐ Single digit next to patient name: ☐ Expiry date: ☐☐ / ☐☐

Leave blank if patient does not have a Medicare number

The patient noted above has a history of the following medical condition/s and it is recommended they receive the Pfizer (COMIRNATY™) COVID-19 vaccine according to current ATAGI advice.

☐ Cerebral Venous Sinus Thrombosis (CVST)

☐ Heparin Induced Thrombocytopenia (HIT)

☐ Idiopathic splanchnic (mesenteric, portal or splenic) venous thrombosis

☐ Anti-phospholipid syndrome with thrombosis

☐ Anaphylaxis, thrombosis with thrombocytopenia or other serious adverse event attributed to the first dose of the AstraZeneca COVID-19 vaccine

☐ History of anaphylaxis to a component of the AstraZeneca COVID-19 vaccine

☐ Other medical contraindication to AstraZeneca COVID-19 vaccine

Medical Practitioner signature: Print and Sign

Medical Practitioner name:

Date: ☐☐ / ☐☐ / ☐☐☐☐

Registration number: M E D 0 0 0

Medical Practitioner contact number:

Instructions for the patient

Please keep this completed form safe. You will be required to present this form on arrival to the vaccination clinic to receive the Pfizer (COMIRNATY™) COVID-19 vaccine.