Queensland Government

Recommendation to Receive the Pfizer (Comirnaty™) COVID-19 Vaccine

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Patient Details

Surname:

First 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 approved medical contraindication to AstraZeneca COVID-19 vaccine. Please note that HHS vaccination clinics may require further information to assess eligibility and your patient may not be vaccinated on the day of presentation if this is unavailable *(attach further supporting documents as necessary).*

Medical Practitioner (print name):

Practice name:

Contact number: | Registration number: **MED000**

Signature: | Date:

Instructions for the Patient

Keep this completed form safe. You will be required to present this form on arrival to the vaccination clinic.

Medical practitioners should retain a copy of the completed form within the patient's medical record.

Print form Reset form

DO NOT WRITE IN THIS BINDING MARGIN

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

v1.00 - 07/2021
SW1123