

Consent Checklist

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had an allergic reaction to a previous dose of a COVID-19 vaccine? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had anaphylaxis to another vaccine or medication? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a serious adverse event, that following expert review was attributed to a previous dose of a COVID-19 vaccine? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had mastocytosis which has caused recurrent anaphylaxis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had COVID-19 before? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a bleeding disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take any medicine to thin your blood (an anticoagulant therapy)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a weakened immune system (immunocompromised)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant?* |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been sick with a cough, sore throat, fever or are feeling sick in another way? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a COVID-19 vaccination before? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you received any other vaccination in the last 7 days? |

Relevant only for those receiving AstraZeneca COVID-19 vaccine:

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|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been diagnosed with capillary leak syndrome? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had cerebral venous sinus thrombosis? * |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heparin-induced thrombocytopenia? * |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had blood clots in the abdominal veins (splanchnic veins)? * |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had antiphospholipid syndrome associated with blood clots? * |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you under 60 years of age? * |

* Comirnaty is the preferred vaccine for people in these groups but if not available, AstraZeneca COVID-19 vaccine can be considered if the benefits of vaccination outweigh the risk. For more information refer to the: [Patient information sheet on thrombosis with thrombocytopenia syndrome \(TTS\)](#)

Relevant only for those receiving Comirnaty:

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|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had myocarditis or pericarditis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you currently have, or have you recently had acute rheumatic fever or endocarditis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have congenital heart disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | For people under 30 years of age: do you have dilated cardiomyopathy? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have severe heart failure? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you a recipient of a heart transplant? |

Last updated: 30 July 2021

Name:												
Medicare number:												