



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

