FIRST LIGHT
Healthcare

Reccommendation 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. (note: serious adverse events are required to be notified to the local public health unit via the NSW Health COVID-19 Vaccine AEFI Case Notification Form or 1300 066 055)
  - ☐ I confirm this event has been notified to the public health unit
- ☐ History of anaphylaxis to a component of the AstraZeneca COVID-19 vaccine
- ☐ Other medical contraindication to AstraZeneca COVID-19 vaccine ____________________

Medical Practitioner signature: ____________________

Medical Practitioner name: ____________________

Date: __ __ / __ __ / __ __ __ __   Registration number: M E D 0 0 0 _ _ _ _ _ _ _

Medical Practitioner contact number: ____________________

Please provide a copy to the patient as they will be required to present this form on arrival to the vaccination clinic to receive the Pfizer (COMIRNATYTM) COVID-19 vaccine.