Tasmanian Government

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

Patient Details

Surname:	First name:
Date of birth (dd/mm/yy):	Sex at birth: ☐ Male ☐ Female ☐ Intersex ☐ Unknown / prefers not to say
Contact details: **Phone**:	**Email:**
Home address:	

Medicare number: ☐☐☐☐ - ☐☐☐☐☐ - ☐ *Reference number* ☐ Expiry date: ☐☐ / ☐☐

Leave blank if patient does not have a Medicare number

Has this patient already received a dose of COVID-19 vaccine? ☐ Yes ☐ No ☐ Unknown*

** If vaccination status is unknown please check the AIR*

If yes, brand of COVID-19 vaccine: ☐ AstraZeneca ☐ Pfizer (Comirnaty™) ☐ Other (name) _____

Date of first vaccination (dd/mm/yy):

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 and/or miscarriage
- ☐ Anaphylaxis, thrombosis with thrombocytopenia syndrome or other serious adverse event attributed to the first dose of the AstraZeneca COVID-19 vaccine*
- ☐ Anaphylaxis to a component of the AstraZeneca COVID-19 vaccine*
- ☐ Capillary leak syndrome
- ☐ Current pregnancy or breastfeeding
- ☐ Other approved medical contraindication to AstraZeneca COVID-19 vaccine (specify)*:

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** It is advisable to speak with a Public Health Services Immunisation CNC to discuss the details of other serious adverse events or contraindications before signing this form to ensure that your patient has had the appropriate assessment to meet these conditions. More supporting documentation may be requested.*

Medical Practitioner details

Full name:	
Specialty:	
Practice name:	
Contact number:	
Signature: Date (dd/mm/yy):	Provider number OR Practice stamp:

Please submit this completed referral form to tas.aefi@health.tas.gov.au

Please note that submission of this form does not guarantee a Pfizer vaccine will be booked. The Tasmanian Immunisation Clinical team will review this referral and if appropriate, contact the patient to make a COVID-19 vaccine booking. Otherwise, we may be in contact to gather further details.

Office use only

Date received:	Assessed on (date):
Assessed by (name):	
Decision: ☐ Pfizer indicated ☐ Pfizer not indicated ☐ More information pending	Discussed with SMA/PHMO/registrar (name)*:
Comments	

Note: all mixed dose schedules require discussion with the SMA