CVMS Vaccination Details Downtime Form

COVID-19 VACCINATION HUB

Please ensure ALL fields on this form are completed

Date: 09/05/2021

CLIENT DETAILS

Full Name		**Medicare No**
DOB	**Gender**	**Aboriginal/Torres Strait Islander**
	☐ Male ☐ Female ☐ Other	☐ Aboriginal ☐ Torres Strait Islander ☐ Neither ☐ Both Aboriginal & Torres Strait Islander

Classification

CVMS Classifications

☐ **1A** Quarantine Worker
☐ **1A** Border Worker
☐ **1A** Frontline Healthcare Worker (**prolonged** patient contact)
☐ **1A** Residential Aged Care Worker
☐ **1B** Healthcare Worker (**brief** patient contact)
☐ **1B** Critical and high risk workforces

For the following category select 'Hotel Quarantine - CQV Staff - Novotel South Warf' in Frontline App

☐ **1B** Household contacts of quarantine & border workers

For the following categories select N/A in Frontline App

☐ **1B** Age related (over **70** years)
☐ **1B** People with a pre-existing medical conditions
☐ **1B** People with a disability
☐ **1B** Aboriginal and Torres Strait Islander people
☐ **2A** Age related (**50 to 59** years)
☐ **2A** Age related (**60 to 69** years)

Phone

Home Address

Address

City

Postcode State

Email Address

VACCINATION DETAILS

Client answered Pre-vax questions ☐ **Yes** ☐ **No**

Consent obtained ☐ **Yes** ☐ **No**

Clinician Comments:

Vaccine Type	**Batch Number**	**Dose Number**
☐ Pfizer ☐ Astra Zeneca		☐ Dose 1 ☐ Dose 2
Administration Site	**Vaccinator Name**	**Time Administered**
☐ Deltoid Left ☐ Deltoid Right ☐ Other		

ADVERSE EVENT

Adverse reaction identified?	**Time elapsed between administration of vaccine & onset of symptoms**
☐Yes (Complete details) ☐ No	
Primary Reaction	**Details**

Treatment

☐ None or symptomatic only ☐ Nurse Assessment ☐ Helpline ☐ Hospital Emergency Department
☐ Attended by Paramedic ☐ GP Assessment ☐ Unknown ☐ Hospital Admission
☐ Other, please specify: