COVID-19 VACCINE MEDICAL CONTRAINDICATION

Western Health

To whom it may concern,

I am a registered medical practitioner. I certify that, Given name: _____

Family name: _____ DOB: _ _/_ _/_ _ _ _ Sex: ☐ Male ☐ Female ☐ Prefer not to say

Residential address: _____

Section A – Medical contraindication

Has the following medical contraindication(s) to receiving a dose of all of the COVID-19 vaccines **available for use in Australia**:[1]

Pfizer (Comirnaty) COVID-19 vaccine	**Moderna (Spikevax) COVID-19 vaccine**	**AstraZeneca (Vaxzevria) COVID-19 vaccine**
Dose 1 ☐ Dose 2 ☐	Dose 1 ☐ Dose 2 ☐	Dose 1 ☐ Dose 2 ☐
☐ History of anaphylaxis to a component of the Pfizer (Comirnaty) COVID-19 vaccine	☐ History of anaphylaxis to a component of the Moderna (Spikevax) COVID-19 vaccine	☐ History of anaphylaxis to a component of the AstraZeneca (Vaxzevria) COVID-19 vaccine
☐ Serious adverse event attributed to the first dose of the Pfizer (Comirnaty) COVID-19 vaccine, being: _____	☐ Serious adverse event attributed to the first dose of the Moderna (Spikevax) COVID-19 vaccine, being: _____	☐ History of capillary leak syndrome
☐ Other specified medical contraindication, being: _____	☐ Other specified medical contraindication, being: _____	☐ History of any of the following medical conditions: ☐ cerebral venous sinus thrombosis (CVST) ☐ heparin-induced thrombocytopenia (HIT) ☐ idiopathic splanchnic (mesenteric, portal or splenic) vein thrombosis ☐ antiphospholipid syndrome (APLS) with thrombosis and/or miscarriage
		☐ Serious adverse event attributed to the first dose of the AstraZeneca (Vaxzevria) COVID-19 vaccine, being: _____
		☐ Other specified medical contraindication, being: _____

OR

Section B – Other medical contraindication

Has the following situation occurred whereby it is not recommended to receive dose 1 ☐ dose 2 ☐ of **any** of the COVID-19 vaccines **available for use in Australia** due to:

☐ Any other serious adverse event that has been attributed to a previous dose of a COVID-19 vaccine by an experienced immunisation provider or medical specialist (and not attributed to any another identifiable cause), **and**

☐ This serious adverse event has been reported to State adverse event programs and/or the Therapeutic Goods Administration _____

Medical practitioner details

Name: _____ Telephone: _____

Address: _____ Email: _____

Registration Number: M E D 0 0 0 _ _ _ _ _ _ _

Signature: Print and Sign

Date: _ _ / _ _ / _ _ _ _

Notes

[1] A patient must have medical contraindications to all of the COVID-19 vaccines available for use in Australia in order to be exempted from COVID-19 vaccination requirements under public health orders. If a patient has a medical contraindication to one brand of COVID-19 vaccine, they may be able to be offered an alternate brand, if suitable.
The Australian Technical Advisory Group on Immunisation (ATAGI) provide clinical guidance on the use of COVID-19 vaccines in Australia, including guidance on contraindications to COVID-19 vaccines: www.health.gov.au/resources/publications/covid-19-vaccination-atagi-clinical-guidance-on-covid-19-vaccine-in-australia-in-2021

Past confirmed infection with SARS-CoV-2 is not a contraindication to vaccination.

Instructions for the patient

Please keep this completed form safe. You may be required to present this completed form to your workplace as evidence of your medical contraindication to COVID-19 vaccination and carry it with you when you are working. Please check the Victorian Government website or Western Health's COVID-19 Vaccination mcirosite for more information about the requirements.