

MOH PFIZER-BIONTECH COVID-19 VACCINATION FORM - FORM 1
TO BE COMPLETED BY PATIENT (please approach our staff if you need help)

PART A: PERSONAL PARTICULARS				<i>Queue</i>	<i>Registration</i>	
NAME (BLOCK LETTERS):			NRIC No./Foreign Identification No.(FIN):			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			Date of Birth (dd/mm/yyyy): <div style="border: 1px solid black; width: 100px; height: 20px; display: flex; justify-content: space-between;"> </div>		Age: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	
Ethnic Group: <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Malay <input type="checkbox"/> Others			Residential Status: <input type="checkbox"/> Citizen <input type="checkbox"/> Long term <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Other			
Address*:				Handphone Number:		
<div style="border: 1px solid black; width: 100%; height: 20px;"></div>				<div style="border: 1px solid black; width: 100%; height: 20px;"></div>		
Postal Code:				Email Address*:		
<div style="border: 1px solid black; width: 100%; height: 20px;"></div>				<div style="border: 1px solid black; width: 100%; height: 20px;"></div>		
PART B: MEDICAL INFORMATION				<i>Waiting Area</i>		
PART B1: FEVER & VACCINATION				NO	YES	
Have you had a fever or any vaccination recently?				<input type="checkbox"/>	<input type="checkbox"/>	
<ul style="list-style-type: none"> • Fever (Temperature $\geq 37.5^{\circ}\text{C}$) in the past 24 hours? • Any vaccination in the past 14 days? 				<input type="checkbox"/>	<input type="checkbox"/>	
PART B2: IMMUNOCOMPROMISE				NO	YES	
Do you have any medical conditions causing severe immunocompromise? For example:				<input type="checkbox"/>	<input type="checkbox"/>	
<ul style="list-style-type: none"> • Recent transplant in the past 3 months • Aggressive Immunotherapy for non-cancer conditions (eg. rituximab etc) • HIV with CD4 count < 200 				<input type="checkbox"/>	<input type="checkbox"/>	
PART B3: ALLERGIES				NO	YES	
Have you ever had any severe allergic reactions to <i>vaccines, medications, insect stings, food etc</i> :				<input type="checkbox"/>	<input type="checkbox"/>	
<ul style="list-style-type: none"> • Anaphylaxis: severe reaction with two or more of the following: (a) hives or face/eyelid/lip/throat swelling, (b) difficulty breathing, (c) dizziness • Ever been prescribed with an Epi-Pen? (self-injected epinephrine for severe allergy) • Have you had rash OR hives OR face/eyelid/lip swelling to vaccines? 				<input type="checkbox"/>	<input type="checkbox"/>	
PART B4: SPECIAL SITUATIONS (CAN STILL VACCINATE)				NO	YES	
Are you currently taking these medications or have these medical conditions?				<input type="checkbox"/>	<input type="checkbox"/>	
<ul style="list-style-type: none"> • Blood-thinning medications (e.g. warfarin, apixaban, rivaroxaban etc) • Bleeding disorder or low platelets • On cancer treatment (immunotherapy / chemotherapy / radiotherapy in the past 3 months OR planned in the next 2 months) *Must consult treating oncologist • (For Females only) Are you pregnant or suspect that you are pregnant (late menstrual period)? *Must consult obstetrician to discuss risks and benefits of vaccination 				<input type="checkbox"/>	<input type="checkbox"/>	
PART C: PATIENT DECLARATION AND CONSENT						
I declare that the information I have given is true and complete to the best of my knowledge						
I have been informed of the risks, benefits and side effects of COVID-19 vaccination, and I wish to receive COVID-19 vaccination						
<input type="checkbox"/> I AGREE to receive COVID-19 vaccination; OR <input type="checkbox"/> I DO NOT wish to receive COVID-19 vaccine**						
<div style="border: 1px solid black; width: 100%; height: 20px;"></div>		<div style="border: 1px solid black; width: 100%; height: 20px;"></div>		<div style="border: 1px solid black; width: 100%; height: 20px;"></div>		
Name of patient / parent / guardian		NRIC No. / FIN		Signature		
				Date (dd/mm/yyyy)		

* Fields not required if names are submitted via nominal roll, appointment booking system and healthcare workers under the self-vaccination exercise.

** If patient **does not** wish to receive COVID-19 vaccine, there is no need to complete **FORM 2**.

MOH PFIZER BIONTECH COVID-19 VACCINATION FORM (ASSESSMENT CLINIC) – FORM 2
TO BE COMPLETED BY DOCTOR OR NURSE

PART D: CLINICAL SAFETY REVIEW OF PATIENTS			
PART D1: NOT ELIGIBLE FOR COVID-19 VACCINATION		NO	YES
IF YES → DO NOT VACCINATE		<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • Child under age 12 years • Severely immunocompromised <ul style="list-style-type: none"> - Recent transplant in the past 3 months - Aggressive Immunotherapy for non-cancer conditions (e.g. rituximab etc) - HIV with CD4 count < 200 cells/mm³ 		<input type="checkbox"/>	<input type="checkbox"/>
PART D2: CONTRAINDICATIONS TO COVID-19 VACCINE		NO	YES
IF YES → DO NOT VACCINATE		<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • Allergic reaction to previous dose of COVID-19 vaccine, or any of its components • History of anaphylaxis or prescribed an Epi-Pen 		<input type="checkbox"/>	<input type="checkbox"/>
PART D3: PRECAUTIONS → POSTPONE VACCINATION		NO	YES
IF YES → DO NOT VACCINATE		<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • Fever (≥ 37.5°C) in past 24 hr → Re-schedule vaccination when fever has resolved • Vaccination in past 14 days → Re-schedule vaccination after 14 days • Rash OR urticaria OR face/eyelid/lip swelling to VACCINES → Refer to allergist* 		<input type="checkbox"/>	<input type="checkbox"/>
PART D4: SPECIAL SITUATIONS → CAN VACCINATE		NO	YES
IF YES to being on anti-coagulation, has bleeding disorder or low platelets →		<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • ADVISE HOLD FIRM PRESSURE AT INJECTION SITE FOR 5 MINUTES 		<input type="checkbox"/>	<input type="checkbox"/>
IF YES to being/possibly pregnant →		<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • CHECKED THAT RISKS & BENEFITS DISCUSSED WITH OBSTETRICIAN? 		<input type="checkbox"/>	<input type="checkbox"/>
IF YES to being on cancer treatment (immunotherapy / chemotherapy / radiotherapy) less than 3 months ago OR planned in the next 2 months →		<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • CHECKED THAT SUITABILITY ASSESSED BY ONCOLOGIST? 		<input type="checkbox"/>	<input type="checkbox"/>
CLINICAL ASSESSMENT: <input type="checkbox"/> Risks, benefits, adverse effects discussed <input type="checkbox"/> Patient form & consent checked VACCINATE? <input type="checkbox"/> YES → PROCEED TO VACCINATION <input type="checkbox"/> NO <input type="checkbox"/> Not eligible OR has contraindications → NO VACCINATION <input type="checkbox"/> Fever → RESCHEDULE vaccination when fever has resolved <input type="checkbox"/> Recent other vaccine → RESCHEDULE to 14 days after other vaccine <input type="checkbox"/> Cutaneous reaction to other VACCINES → Refer to allergist*		Form Completed by <hr/> Name (stamp) / Signature / Date	
PART E: VACCINATION RECORD			
COVID-19 vaccine given:	Injection site:	Vaccine Brand:	Batch number:
<input type="checkbox"/> #1 Date:	<input type="checkbox"/> Left deltoid	<input type="checkbox"/> Pfizer-BioNTech	Bottle number (if applicable):
<input type="checkbox"/> #2 Date:	<input type="checkbox"/> Right deltoid	<input type="checkbox"/> Moderna	
	<input type="checkbox"/> Other _____	<input type="checkbox"/> Sinovac	
		<input type="checkbox"/> Other _____	
Place of Vaccination:		Vaccinated by:	
		<hr/> Name (stamp) / Signature / Date	
PART F: OBSERVATION & DISCHARGE			
<input type="checkbox"/> Vaccine card & vaccine information sheet (VIS) given <input type="checkbox"/> Observe patient for 30 min after vaccination (for syncope, anaphylaxis etc) <input type="checkbox"/> If allergic symptoms develop in first 30 min, observe until stable or refer to ED			Time of vaccination:
Remarks by doctor (If treatment required):		Assessed by:	
		<hr/> Name (stamp) / Signature / Date	

* Please refer to the [Allergist Referral Form for COVID-19 vaccination] if the individual is eligible for further evaluation by an allergist.