PATIENT INFORMATION FORM

Year Group _____

TITLE | FIRST NAMES

SURNAME | DATE OF BIRTH / /

ADDRESS

SUBURB | POST CODE

EMAIL:

TEL No. (Home) | (Work) | (Mob)

MEDICARE No. | REF No. | EXPIRY

VETERANS AFFAIRS No. | **Gold** or **White** (please circle) | EXPIRY

PENSION CARD No. | EXPIRY

EMERGENCY CONTACT | CONTACT No.

DECLARATION OF CONSENT

☐ I CONSENT FOR ANY OF MY APPOINTMENT(S) TO BE COMPELTED VIA TELEHEALTH CONSULT AND I AGREE TO HAVING A THIRD PART¸ PRES ENT DURING MY MEDICAL CONSULT WITH REDIMED TO ASSIST WITH MY TREATMENT/CARE.

☐ I CONSENT TO RECEIVE CORRESPONDENCE AND UPDATES ON SERVICES PROVIDED BY REDIMED

I declare that the information which I have set out in this questionnaire is truthful and there are no misleading answers or omissions. If any of this information changes, I will inform REDIMED immediately and update these details.

SIGNATURE _____ **DATE** _____

Influenza Vaccination Consent Form 2020

Please contact us via email at fluvac@redimed.com.au or text 0456 737 272 if you have any queries, to speak to one of our friendly staff. Please do not call our main line as our call centre is overloaded with calls at this time.

Before receiving the vaccine, please read the attached information on Flu Vaccine and answer the following questions:

Have you received a flu vaccine before?	☐ Yes ☐ No
Have you had any serious problems after a flu vaccine?	☐ Yes ☐ No
Are you prone to fainting?	☐ Yes ☐ No
Are you currently unwell or suffering from a feverish illness?	☐ Yes ☐ No
Do you have a bleeding disorder?	☐ Yes ☐ No
Are you allergic to eggs?	☐ Yes ☐ No
Are you allergic to Neomycin, Kanamycin, Polymyxin, Gentamicin, Thiomersal or latex?	☐ Yes ☐ No
Women only: Is there a possibility that you could be pregnant?	☐ Yes ☐ No

By signing this form, I acknowledge that I have read the attached information on the Flu Vaccine and that I consent to the Flu vaccination to be administered by the health personnel from Redimed Pty Ltd.

Signature: _____ **Date**:_____

REDIMED Use Only:
Immunisation to proceed: Yes / No (please circle)

Influenza Vaccines	Route	Dose/Route	Batch Number
☐ FluQuadri	6 months to ~~65~~ years	0.50 ml IM STAT	UJ345ac EXP 08/01/2021
☐ Quadrivalent Influenza Vaccine (QIV) - Fluad® Quad	>65 years	0.50 ml IM STAT	LOT267524 ExpDEC092020

Administered by: _____ _____ ____ /____ / **2020**