Whooping cough vaccine program for pregnant women
Data collection and consent form

Queensland Government

Recording the diphtheria, tetanus and pertussis (dTpa) vaccination for pregnant women

- This is a carbonated form, please complete, retain the copy for your records and forward the completed original to VIVAS by using the following reply paid address:
  REPLY PAID 2368, FORTITUDE VALLEY BC QLD 4006
- If you use medical software to record vaccination details this form is still required. Please forward the form to the address above.

Service provider details

VSP No. ☐☐ ☐☐☐

Practice/clinic name:

Practice address: Postcode:

Provider name: Provider number: ☐☐☐☐☐☐☐

I have discussed with the client the risks and benefits of dTpa vaccination as outlined in the whooping cough vaccine program for pregnant women information sheet.

Signed: Date: ☐☐ / ☐☐ / ☐☐

Patient details

Surname: Given names:

Date of birth: ☐☐ / ☐☐ / ☐☐

☐ Aboriginal ☐ Torres Strait Islander (TSI) ☐ Aboriginal & TSI ☐ Not Aboriginal or TSI ☐ Not stated / unknown

Address: Postcode:

Telephone number/s: (H) (W) (M)

Date of last menstrual period: ☐☐ / ☐☐ / ☐☐ Expected date of delivery: ☐☐ / ☐☐ / ☐☐

Third trimester of pregnancy? ☐ Yes ☐ No

Consent

Vaccination

I have read and I understand the information given to me by my vaccine provider and in the whooping cough vaccine program for pregnant women information sheet about the diphtheria, tetanus, pertussis (dTpa) vaccination, including risks and potential side effects. I have been given the opportunity to discuss the risk and benefits of vaccination with my vaccine provider and these have been explained to me to my satisfaction.

I give permission to Queensland Health to contact me regarding follow-up after this vaccination.

If I experience any unusual side effects following vaccination, I will contact my vaccine provider immediately, or call 13 HEALTH (13 43 25 84) for further assistance.

I have read and understand the privacy statement overleaf and I acknowledge that Queensland Health will record my vaccination.

Signed: Date: ☐☐ / ☐☐ / ☐☐

Batch number: Date of vaccination: ☐☐ / ☐☐ / ☐☐ Dose no.: ☐

May 2015

Duplicate record - please retain for your records