**Confidential Covid-19 Vaccination History**

Please answer all the questions below:

**Patient Details (please print):**

|  |  |
| --- | --- |
| **Surname:** |  |
| **First Name:** |  |
| **Date of Birth:** |  |
| **Address:** |  |
| **Mobile Phone Number:**  **(see text reminders for consent)** |  |
| **Email address:** |  |

**Text Reminders (please tick):**

□ I give permission for Riccarton General Practice to contact me via text message regarding relevant healthcare issues. I understand that I may withdraw my consent at any time and I will contact Riccarton General Practice if this is the case. Riccarton General Practice holds all patient information with the strictest confidence and abides by Data Protection Legislation.

**Covid-19 Vaccination History:**

|  |  |
| --- | --- |
| **Have you received a Covid-19 vaccination?** | Yes □ No □ |
| 1. Name of vaccine (eg. Pfizer): |  |
| 1. Date of vaccine given: | Dose 1:  Dose 2: |
| 1. Country in which you received your vaccine: |  |
| **If not already vaccinated, do you want a Covid-19 vaccination?** | Yes □ No □ |

**Please return this completed questionnaire to the Practice along with your registrations forms**