MOH MODERNA COVID-19 VACCINATION FORM - FORM 1
TO BE COMPLETED BY PATIENT (please approach our staff if you need help)
BORANG VAKSINASI COVID-19 MODERNA MOH - BORANG 1
UNTUK DILENGKAPKAN OLEH PESAKIT (sila berjumpa kakitangan kami sekiranya anda perlukan bantuan)

PART A: PERSONAL PARTICULARS / BAHAGIAN A: BUTIRAN PERIBADI

Queue Barisan | *Registration Pendaftaran*

NAME (BLOCK LETTERS): / **NAMA (HURUF BESAR):**

NRIC No./Foreign Identification No. (FIN): / **Nombor NRIC/ Nombor Identifikasi Asing (FIN):**

Gender: / Jantina:	Date of Birth (dd/mm/yyyy): / Tarikh Lahir (dd/mm/yyyy):	Age: / Umur:	Ethnic Group: / Kumpulan Etnik:	Residential Status: / Status Kediaman:
☐ Male Lelaki ☐ Female Perempuan			☐ Chinese Cina ☐ Indian India ☐ Malay Melayu ☐ Others Lain-lain	☐ Citizen Warganegara ☐ Long term Jangka Panjang ☐ Permanent Resident Penduduk Tetap ☐ Other Lain-lain

Address*: / **Alamat*:**

Postal Code: / Poskod:

Handphone Number: / **Nombor Telefon Bimbit:**

Email Address*: / **Alamat E-mel*:**

PART B: MEDICAL INFORMATION / BAHAGIAN B: MAKLUMAT PERUBATAN

Waiting Area Kawasan Menunggu

PART B1: FEVER / BAHAGIAN B1: DEMAM	NO / TIDAK	YES / YA
Have you had a fever (temperature ≥ 37.5°C) in the past 24 hours?	☐	☐

PART B2: ADVERSE EVENTS TO VACCINES / BAHAGIAN B2: KESAN BURUK TERHADAP VAKSIN-VAKSIN	NO / TIDAK	YES / YA
Have you ever had any allergic reactions to a previous dose of an mRNA COVID-19 vaccine (Pfizer-BioNTech/Comirnaty or Moderna) Pernahkah anda mengalami sebarang tindak balas alahan terhadap dos vaksin COVID-19 mRNA sebelum ini (Pfizer-BioNTech/Comirnaty atau Moderna)		
• Anaphylaxis: severe reaction with two or more of the following: (a) hives or face/eyelid/lip/throat swelling, (b) difficulty breathing, (c) dizziness Anafilaksis: tindak balas yang teruk yang menyebabkan dua atau lebih keadaan berikut: (a) gatal-gatal atau bengkak di muka/kelopak mata/bibir/tekak, (b) kesukaran bernafas, (c) pening	☐	☐
• Have you had rash OR hives OR face/eyelid/lip swelling? Pernahkah anda mengalami ruam ATAU gatal-gatal ATAU bengkak di muka/kelopak mata/bibir?	☐	☐
Have you been diagnosed with heart inflammation (myocarditis/pericarditis) after a previous dose of a COVID-19 vaccine? Pernahkan anda didapati menghidapi keradangan jantung (miokarditis/pericarditis) selepas diberikan dos vaksin COVID-19 sebelum ini?	☐	☐

PART B3: SPECIAL SITUATIONS (CAN STILL VACCINATE) / BAHAGIAN B3: SITUASI ISTIMEWA (MASIH BOLEH MENDAPATKAN VAKSINASI)	NO / TIDAK	YES / YA
Have you ever had anaphylaxis to medications, insect stings, food or unknown triggers Pernahkah anda mengalami anafilaksis terhadap ubat-ubatan, sengatan serangga, makanan atau bahan-bahan penyebab anafilaksis yang tidak diketahui?	☐	☐
(For females) Are you pregnant or suspect that you are pregnant (late menstrual period)? (Untuk wanita) Adakah anda hamil atau mengesyaki bahawa anda hamil (kelewatan haid)?	☐	☐
Are you currently taking these medications or have these medical conditions? Adakah anda sedang mengambil ubat-ubatan atau mempunyai keadaan perubatan ini?		
• Blood-thinning medications (e.g. warfarin, apixaban, rivaroxaban etc) Ubat penipisan darah (seperti warfarin, apixaban, rivaroxaban, dan sebagainya)	☐	☐
• Bleeding disorder or low platelets Masalah pendarahan atau platelet rendah	☐	☐

• On cancer treatment (immunotherapy / chemotherapy / radiotherapy in the past 3 months **OR** planned in the next 2 months)[#] Sedang menjalani rawatan penyakit barah (imunoterapi / kemoterapi / radioterapi dalam tempoh kurang dari 3 bulan yang lalu ATAU telah merancang untuk menjalani rawatan dalam tempoh 2 bulan yang akan datang)[#]	☐	☐
• Recent transplant in the past 3 months[#] Pemindahan organ dalam masa 3 bulan yang lalu[#]	☐	☐
• Aggressive Immunotherapy for non-cancer conditions (e.g. rituximab etc)[#] Sedang menjalani imunoterapi agresif untuk penyakit-penyakit bukan barah (seperti rituximab, dan sebagainya)[#]		

PART C: PATIENT DECLARATION AND CONSENT
BAHAGIAN C: PENGISYTIHARAN DAN PERSETUJUAN PESAKIT

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

Saya mengisytiharkan bahawa maklumat yang saya berikan adalah benar dan lengkap sebaik pengetahuan saya

Saya sudah diberitahu tentang risiko, manfaat dan kesan sampingan pemvaksinan COVID-19, dan saya ingin menerima vaksin COVID-19

☐ I **AGREE** to receive COVID-19 vaccination; OR
SAYA **SETUJU** untuk menerima vaksinasi COVID-19; ATAU

☐ I **DO NOT** wish to receive COVID-19 vaccine**
SAYA **TIDAK MAHU** menerima vaksin COVID-19**

_____	_____	_____	_____
Name of patient / parent / guardian Nama pesakit / ibu bapa / waris	NRIC No. / FIN Nombor NRIC / FIN	Signature Tandatangan	Date (dd/mm/yyyy) Tarikh (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**.
[#] Memo from treating specialist is required to proceed with vaccination.
* Butiran tidak diperlukan sekiranya nama diserahkan menerusi senarai nominal, sistem tempahan temu janji dan pekerja-pekerja penjagaan kesihatan di bawah program pemvaksinan sendiri.
** Sekiranya pesakit tidak mahu menerima vaksin COVID-19, BORANG 2 tidak perlu dilengkapkan.
# Memo daripada pakar yang merawat anda diperlukan untuk meneruskan vaksinasi.

MOH MODERNA COVID-19 VACCINATION FORM (ASSESSMENT CLINIC) – FORM 2
TO BE COMPLETED BY DOCTOR OR NURSE AT THE VACCINATION SITE
BORANG VAKSINASI COVID-19 MODERNA MOH (KLINIK PENILAIAN) - BORANG 2
DOKTOR ATAU JURURAWAT DI TEMPAT VAKSINASI PERLU MELENGKAPKAN BORANG INI

PART D: CLINICAL SAFETY REVIEW OF PATIENTS		
PART D1: NOT ELIGIBLE FOR COVID-19 VACCINATION **IF YES → DO NOT VACCINATE**	**NO**	**YES**
• Child under age 18 years	☐	☐
PART D2: CONTRAINDICATIONS TO COVID-19 VACCINE **IF YES → DO NOT VACCINATE**	**NO**	**YES**
• High-risk/immediate (onset ≤4h) allergic reaction or anaphylaxis to previous dose of same vaccine, or any of its components	☐	☐
• Myocarditis / pericarditis after a previous COVID-19 vaccine	☐	☐
PART D3: PRECAUTIONS → POSTPONE VACCINATION **IF YES → DO NOT VACCINATE**	**NO**	**YES**
• Fever (≥ 37.5°C) in past 24 hr → Re-schedule vaccination when fever has resolved	☐	☐
•		
PART D4: SPECIAL SITUATIONS → CAN VACCINATE	**NO**	**YES**
IF YES to being on anti-coagulation, has bleeding disorder or low platelets →		
• Advise to hold firm pressure at injection site for 5 minutes	☐	☐
IF YES to being/possibly pregnant →		
• Check if patient wishes to discuss with obstetrician (optional)	☐	☐
IF YES to any of the below, check if the suitability has been assessed by treating specialist		
• On cancer treatment (immunotherapy / chemotherapy / radiotherapy) less than 3 months ago or planned in the next 2 months	☐	☐
• Recent transplant in the past 3 months	☐	☐
• Aggressive immunotherapy for non-cancer conditions (e.g. rituximab, etc.)	☐	☐
IF YES to history of anaphylaxis →		
• ENSURE POST-VACCINATION OBSERVATION PERIOD OF 30 MINUTES	☐	☐

CLINICAL ASSESSMENT: ☐ Risks, benefits, adverse effects discussed; patient form & consent checked **VACCINATE?** ☐ YES → PROCEED TO VACCINATION ☐ NO ☐ Not eligible OR has contraindications → NO VACCINATION ☐ Fever → RESCHEDULE vaccination when fever has resolved	Form Completed by _____ Name (stamp) / Signature / Date

PART E: VACCINATION RECORD			
COVID-19 vaccine given: ☐ #1 Date: ☐ #2 Date: ☐ #3 Date:	Injection site: ☐ Left deltoid ☐ Right deltoid ☐ Other_____	Vaccine Brand: ☐ Pfizer-BioNTech/ Comirnaty ☐ Moderna ☐ Sinovac ☐ Other _____	Batch number: Bottle number (if applicable):
Place of Vaccination:		Vaccinated by: _____ Name (stamp) / Signature / Date	

PART F: OBSERVATION & DISCHARGE	
☐ Vaccine card & vaccine information sheet (VIS) given ☐ Observe patient for 30 min after vaccination (for syncope, anaphylaxis etc) ☐ 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: _____ 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.