Did the provincial COVID-19 Self-Assessment recommend that you be tested for COVID-19?
No

Patient first name:
Nibir

Patient last name:
Das

Province of healthcare number:
Alberta

Healthcare number:
406229781

Date of birth:
1998/10/31

Gender:
Male

Current postal code of residence:
T6G 2C5

Current city of residence:
Edmonton

Current address of residence:
3A 9003 112 St NW

Primary phone type:
Mobile

Primary phone number (e.g. 555-555-5555):
5879361662

First and last name of emergency contact:
Murtoza Manzur

What is your emergency contact’s relationship to you?
Friend

Emergency contact phone type:
Mobile

Emergency contact phone number:
7802574001

If you have a family doctor, please enter the doctor's first and last name:
Gaurav Malhotra

I consent to receiving prescriptions and/or injection(s) and/or immunization(s) from my healthcare provider, either for myself or for the minor for whom I am authorized to give consent. I will ensure that information on the medication(s), the administration procedure, risks, precautions, benefits, expected outcome, and potential side effects are explained to me and that my questions are answered to my satisfaction. If receiving an immunization, I agree to remain onsite for 15-30 minutes after the immunization. I agree to having my personal health information shared with my other healthcare provider(s) and/or Public Health, as required by law or deemed appropriate by the healthcare provider. I understand that I may withdraw my consent at any time by notifying my healthcare provider.

Yes

Which immunization do you want?
COVID-19

Are you sick today?
No

Have you ever had a serious or unusual reaction following an immunization or injection?
No

Have you had any reaction involving the eyes or your breathing after a previous flu shot?

No

Do you have a severe allergy (anaphylaxis) to any vaccine or vaccine components, like egg or chicken protein, gelatin, thimerosal, neomycin, kanamycin or gentamicin?
No

Do you have an allergy to any medication?
No

Have you had an allergic reaction to laxatives, cough syrups, skin products/cosmetics, contact lens solution, or the medications used to prepare for diagnostic imaging, such as contrast media, ultrasound gel or colonoscopy preparation?
No

Do you have an allergy or sensitivity to latex gloves or adhesive bandages?
No

Do you take a blood thinner or have any bleeding disorders?
No

Have you had lymph nodes removed from your arms or chest or had a mastectomy?
No

Have you received any TB skin tests or immunizations in the last 4 weeks?
No

During the past year, have you received a transfusion of blood/blood products or immune globulin, antibody or plasma treatments?
No

Do you have any immune suppression due to treatment (such as prednisone, anti-cancer treatment, etc.) or disease (such as cancer, leukemia, HIV, active shingles, TB or other conditions that affect the immune system)?
No

Are you a candidate or recipient of solid organ or stem cell transplant?
No

Have you ever had inflammation of the heart muscle (myocarditis) or inflammation of the heart lining (pericarditis)?
No

Have you ever been diagnosed with multisystem inflammatory syndrome (MIS-C/A) or Kawasaki or toxic shock syndrome? These syndromes have many symptoms such as red & swollen hands or feet, red eyes, skin rash, or swollen glands.
No

Are you taking antiviral medications against influenza, such as Tamiflu or Relenza?
<Unanswered>

Does anyone living with you have a severely compromised immune system?
<Unanswered>

Have you had any wheezing in the last 7 days, or a history of severe asthma?
<Unanswered>

Can a health care practitioner call or text you for follow-up services?
Yes