Spleen Australia Patient Registration Form – please return by email, fax or post

Patient's Name	
Date of Birth	
Mailing address	
Mobile phone number/home phone number	
Email address	
Medicare number	

Indication for referral	
Splenectomy/Hyposplenism/Splenic Artery Embolisation (please circle)	
Reason for splenectomy/SAE/diagnosis of hyposplenism	
Date of splenectomy/SAE/diagnosis of hyposplenism	
Hospital at which procedure was performed, or where diagnosis was made	

Vaccination history		Date given	Date given
Pneumococcal	Conjugate (Prevenar 13)		
	(Polysaccharide (Pneumovax 23)		
Meningococcal	Conjugate ACWY (Nimenrix, Menveo,Menactra)		
	Recombinant MenB (Bexsero)		
Hib	Haemophilus influenzae type b (Liquid Pedvax, HIB, Hiberix)		
Annual Influenza Vaccine			
COVID Vaccine	Specify brand		

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Does the patient have an antibiotic allergy? Please circle Yes/No. If yes, to which antibiotic?	Reaction
Is the patient allergic to any vaccines? Please circle Yes/No. If yes, to which vaccine?	Reaction

Does the patient take daily antibiotics? If yes please complete section below		
Antibiotic name	Dose	Frequency
Does the patient have an emergency supply of antibiotics? If yes please complete the section below		
Antibiotic name	Dose	

GP name	**Practice**
Phone number	Address

Additional contact person/NOK	
Name/relationship	Contact number

Has the patient given consent for their information to be given to Spleen Australia? Please circle Yes/No

Name and contact number of person completing this form:

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