

## HPV Vaccination Notification (single dose only)

The National HPV Vaccination Program Register is fully funded by: Australian Government - Department of Health and Ageing  
Operated by: Victorian Cytology Service Inc

### Instructions

To notify the National HPV Vaccine Program Register (NHVPR) of a vaccine dose this form needs to be completed and faxed or posted (not email) to the Registry. Copies of this form can be downloaded from [www.HPVRegister.org.au](http://www.HPVRegister.org.au) and information can be written in by hand or typed. **Please write clearly in BLOCK LETTERS.**

### Consumer Details:

First name: \_\_\_\_\_ Middle name: \_\_\_\_\_  
Surname: \_\_\_\_\_ Previous surname: (if applicable) \_\_\_\_\_  
Date of birth:                    /                    /                    Gender:     Female                     Male  
Medicare number:    

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Medicare reference number:     (person number on Medicare card)  
Is the person of Aboriginal or Torres Strait Islander origin? (This information will assist in the planning and provision of appropriate and improved health care and services)  
 No                     Aboriginal                     Torres Strait Islander                     Both Aboriginal and Torres Strait Islander

### Consumer Address, Phone and School Details:

Home address: \_\_\_\_\_  
Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode : \_\_\_\_\_  
Postal address: (if different from above) \_\_\_\_\_  
Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode : \_\_\_\_\_  
Daytime phone:    (    ) \_\_\_\_\_ Mobile:                    (    ) \_\_\_\_\_  
School Name: \_\_\_\_\_ School Postcode: \_\_\_\_\_ School Level: \_\_\_\_\_

### Guardian/Parent Details (if applicable):

First name: \_\_\_\_\_ Middle name: \_\_\_\_\_ Surname: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: (    ) \_\_\_\_\_

### Vaccination details:

Vaccination date:                    /                    /                    Vaccine brand: \_\_\_\_\_ Batch number: \_\_\_\_\_  
Vaccine expiry date:                    /                    /                     
Dose number on this date:                     Dose 1                     Dose 2                     Dose 3

### General Practitioner details:

Medicare provider number: \_\_\_\_\_  
First name: \_\_\_\_\_ Surname: \_\_\_\_\_  
Name of practice contact (if different from above): \_\_\_\_\_  
Business name: \_\_\_\_\_  
Phone: (    ) \_\_\_\_\_

**I certify that the information provided on this notification form is correct.**

Signature: \_\_\_\_\_ Date:                    /                    /

**To return this form please: Fax: (03) 8360 8699 or mail to: PO Box 725, Sunshine VIC 3020**

For assistance submitting this form or enquiries please call 1800 478 734 (1800 HPV REG) or visit [www.hpvregister.org.au](http://www.hpvregister.org.au)