Services de santé du TIMISKAMING Health Unit

Healthcare Provider Vaccine Requisition Form
School Or High Risk Programs

Fax completed form to Timiskaming Health Units Confidential Fax **705-647-5779**
All information must be filled out for each vaccine ordered.
***If multiple doses are required of each vaccine, health care provider must place each dosing order separately ***
Refer to the Current Publicly Funded Immunization Schedule - for detailed high risk (HR) eligibility criteria
High Risk Immunization Reporting Information must be completed and faxed following vaccine administration

Name of Facility, Physician, or Practice:		
Date:	Phone Number:	Fax Number:
CLIENT NAME:	**DOB:**	**PHONE**:
PERMANENT ADDRESS & POSTAL CODE:		

MENINGOCOCCAL C-ACYW135

Name (First & Last): _____

DOB (YYYY/MM/DD): _____

DATE ADMINISTERED: _____

Dose # 1 2 3 4 booster
(see table- 15 of the Ontario Publicly funded Schedule for number of eligible doses – please circle dose required)

HR Eligibility – Age 9 months to 55 and ≥ 56 years with:
(please check all that apply)

- ☐ Functional or anatomic asplenia
- ☐ Complement, properdin, factor D deficiency, or primary antibody deficiency
- ☐ Cochlear implant recipient (pre/post implant)
- ☐ Acquired complement deficiencies (eg receiving eculizumab)
- ☐ HIV

Or **School Program:**

- ☐ Grade 7 – 12 students

HUMAN PAPILLOMAVIRUS (HPV-9)

Name (First & Last): _____

DOB (YYYY/MM/DD): _____

DATE ADMINISTERED: _____

☐ Two-Dose Series (Immunocompetent Age 9 – 14 yrs)
Note: In healthy individuals 15 years of age and older who received the first dose between 9 to less than 15 years of age, a 2-dose schedule can be used

☐ Three-Dose Series (Immunocompromised and immunocompetent HIV-infected individuals or those age ≥ 15 yrs in grade 7-12)

Dose # 1 2 3 *(please circle dose required)*

Eligibility

- ☐ **School Program**: Grade 7 students (who remain eligible to grade 12)
- ☐ **HR Program:** Men who have sex with men – ages 9 – 26 Years

Note: Individuals who have completed their HPV4 series as of March 14, 2019 will be considered up to date and not eligible for Publicly Funded HPV9 vaccine; For those completing an initiated HPV 4 series with HPV9; Full protection against the additional five strains will not be achieved. If these individuals wish to be vaccinated with a complete series of HPV9 they will need to purchase the addition HPV9 doses.

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HAEMOPHILUS INFLUENZAE TYPE B (ACT-HIB®)

Name (First & Last): _____

DOB (YYYY/MM/DD): _____

DATE ADMINISTERED: _____

Dose # 1 2 3 *(please circle dose required)*

** HSCT recipients are eligible for 3 doses. All other eligible conditions receive only 1 dose. See current Publicly Funded Immunization Schedule for vaccine intervals.*

HR Eligibility – ≥ 5 years with:
(please check all that apply)

- ☐ Hematopoietic stem cell transplant (HSCT) recipient* (3 doses)
- ☐ Functional or anatomic asplenia (1 dose)
- ☐ Immunocompromised related to disease or therapy (1 dose)
- ☐ Bone marrow or solid organ transplant recipient (1 dose)
- ☐ Lung transplant recipient (1 dose)
- ☐ Cochlear implant recipient (pre/post implant) (1 dose)
- ☐ Primary antibody deficiency (1 dose)

Note: High risk children 5 to 6 years of age who require DTaP-IPV and Hib should receive **DTaP-IPV-Hib** instead of Hib

MENINGOCOCCAL B

Name (First & Last): _____

DOB (YYYY/MM/DD): _____

DATE ADMINISTERED: _____

Current Dose # 1 2 3 4

(see table 14 of the Ontario Publicly funded Schedule for number of eligible doses – please circle dose required)

Eligibility – Age 2 months to 17 years with:
(please check all that apply)

- ☐ Functional or anatomic asplenia
- ☐ Complement, properdin, factor D deficiency, or primary antibody deficiencies
- ☐ Cochlear implant recipient (pre/post implant)
- ☐ Acquired complement deficiencies (eg receiving eculizumab)
- ☐ HIV

PNEUMOCOCCAL-C-13 VALENT (PREVNAR®13)

Name (First & Last): _____

DOB (YYYY/MM/DD): _____

DATE ADMINISTERED: _____

Dose # 1 2 3 4
(please circle dose required)

** HSCT recipients are eligible for 3 doses scheduled as per Table 18.*
All other eligible conditions receive only 1 dose
See the current Publicly Funded Immunization Schedule Table 19 for vaccine intervals between Prevnar 13 and Pneumo 23

***Please note:** Prevnar®13 utilized for routine childhood immunizations may be used for this patient. If Prevnar®13 is not normally stocked, please fill out this form accordingly. The High Risk Immunization Reporting Form must be completed and faxed to the Timiskaming Health Unit following vaccine administration.*

_____

HR Eligibility:
Infants 6 weeks to 6 months of age who meet High Risk Pneumo-P-23 criteria should also receive a fourth dose of Pneumoccal-C-13

≥ 50 years with:
(please check all that apply)

- ☐ Hematopoietic stem cell transplant (HSCT) recipient* (3 doses)
- ☐ HIV (1 dose)
- ☐ Asplenia (anatomical or functional) (1 dose)
- ☐ Congenital immunodeficiencies involving any part of the immune system, including B-lympho-cyte (humoral) immunity, T-lymphocyte (cell) mediated immunity, complement system (proper-din, or factor D deficiencies), or phagocytic functions (1 dose)
- ☐ Immunocompromising therapy including use of long-term corticosteroids, chemotherapy, radiation therapy, post-organ transplant therapy, biologic and certain anti-rheumatic drugs (1 dose)
- ☐ Malignant neoplasms including leukemia and lymphoma (1 dose)
- ☐ Sickle cell disease or other hemoglobinopathies (1 dose)
- ☐ Solid organ or islet cell transplant (candidate or recipient) (1 dose)

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PNEUMOCOCCAL-P-23 VALENT (PNEUMOVAX®23)

Name (First & Last): _____

DOB (YYYY/MM/DD): _____

DATE ADMINISTERED: _____

Dose # 1 2*
(please circle dose required)

***For those > 2 years of age, a 2nd (one lifetime re-immunization) dose should be given ≥5 years after the 1st dose for those meeting these specific High Risk Criteria and (see * on right)**

A 2nd dose should also be given at ≥ 65 years to anyone who received the first dose prior to age 65 (5 year interval).

Please note: Pneumovax®23 utilized for routine immunizations may be used for this patient. If Pneumovax®23 is not normally stocked, please fill out this form accordingly. The High Risk Immunization Reporting Form must be completed and faxed to Timiskaming Health Unit following vaccine administration.

HR Eligibility – 2-64 years with:
(please check all that apply)

- ☐ Chronic respiratory disease (excluding asthma, unless treated with high-dose corticosteroid therapy*)
- ☐ Chronic cardiac disease
- ☐ Chronic cerebrospinal fluid leak
- ☐ Cochlear implant recipients (pre/post implant)
- ☐ Chronic neurologic condition that may impair clearance of oral secretions
- ☐ Diabetes mellitus
- ☐ Resident of nursing home, home for the aged, chronic care facility/ward
- ☐ Chronic liver disease (including hepatitis B and C)
- ☐ Hepatic cirrhosis due to any cause*
- ☐ Chronic renal disease or nephrotic syndrome*
- ☐ Asplenia (functional or anatomical), splenic dysfunction*
- ☐ Sickle-cell disease or other sickle cell haemoglobinopathy*
- ☐ Immunosuppressive therapy including use of long-term systemic corticosteroid, chemotherapy, radiation therapy, post-organ transplant therapy, certain anti-rheumatic drugs and other immunosuppressive therapy *****
- ☐ HIV *****
- ☐ Undergoing solid organ or islet cell transplant (candidate or recipient) *****
- ☐ Undergoing HSCT (candidate or recipient)*
- ☐ Congenital (primary) immunodeficiency involving any part of the immune system including B-lymphocyte (humoral) immunity, T-lymphocyte (cell) mediated immunity, complement system (properdin, or factor D deficiencies), or phagocytic functions *****
- ☐ Malignant neoplasms including leukemia and lymphoma*

Polio (IPV)
IPV/Tdap-IPV

Name (First & Last): _____

DOB (YYYY/MM/DD): _____

DATE ADMINISTERED: _____

HR Eligibility > 18 years Travellers who have completed their immunization series against polio and are travelling to areas where poliovirus is known or suspected to be circulating
Refer to the Committee to Advise on Tropical Medicine and Travel (CATMAT) for recommendations at phac-aspc.gc.ca/tmp-pmv/catmat-ccmtmv/index-eng.php
Note: Travellers are eligible to receive a single adult lifetime booster dose of IPV-containing vaccine
The most appropriate vaccine (i.e., IPV or Tdap-IPV) should be selected

HEPATITIS A (AVAXIM®/HAVRIX®)

Name (First & Last): _____

DOB (YYYY/MM/DD): _____

DATE ADMINISTERED: _____
Dose # 1 2

HR Eligibility – ≥ 1 year with:
(please check all that apply)

- ☐ Chronic liver disease (including Hepatitis B and C)
- ☐ Persons engaging in intravenous drug use
- ☐ Men who have sex with men

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(please circle dose required)	
HEPATITIS B (RECOMBIVAX HB®/ENGERIX®-B) Name (First & Last): _____ DOB (YYYY/MM/DD): _____ DATE ADMINISTERED: _____ Dose # 1 2 3 4 *(please circle dose required)* (and boosters if required)	**HR Eligibility – ≥ 0 years with:** *(please check all that apply)* ☐ Infant born to HBV-positive carrier mothers: ○ premature infant weighing <2,000 grams at birth (4 doses) ○ premature infant weighing ≥2,000 grams at birth and full/post term infants (3 doses) ☐ Household and sexual contacts of chronic carrier and acute case (3 doses) ☐ Individuals engaging in intravenous drug use (3 doses) ☐ Men who have sex with men (3 doses or 2 doses if 11 – 15 years of age) ☐ Individual with multiple sex partners (doses according to age) ☐ History of a sexually transmitted disease (doses according to age) ☐ Needle stick injury in a non-health care setting (3 doses) ☐ Child <7 years old whose family has immigrated from country of high prevalence for hepatitis B and who may be exposed to hepatitis B virus carriers through their extended family (3 doses) ☐ Chronic liver disease including hepatitis C (3 doses) ☐ Renal dialysis or disease requiring frequent receipt of blood products (e.g., haemophilia) (2nd and 3rd doses only) ☐ Awaiting liver transplant (2nd and 3rd doses only) OR **School Program**: ☐ Grade 7 Students (who remain eligible to Grade 12) (2 dose series for those 11 to 15 years and 3 doses for those ≥ 16 years of age)
Varicella Name (First & Last): _____ DOB (YYYY/MM/DD): _____ DATE ADMINISTERED: _____ Dose # 1 2 *(please circle dose required)* *Please note: Varicella vaccine utilized for routine immunizations may be used for this patient. If Varicella vaccine is not normally stocked, please fill out this form accordingly. The High Risk Immunization Reporting Form must be completed and faxed to Timiskaming Health Unit following vaccine administration.*	**HR Eligibility those born in or prior to 1999 with:** ☐ Susceptible children and adolescents given chronic salicylic acid therapy ☐ Susceptible individuals with cystic fibrosis ☐ Susceptible household contacts of immunocompromised individuals ☐ Susceptible individuals receiving low dose steroid therapy or inhaled/topical steroids ☐ Susceptible immunocompromised individuals, see the Canadian Immunization Guide

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IMVAMUNE

Name (First & Last): _____

DOB (YYYY/MM/DD): _____

DATE ADMINISTERED: _____

Dose # 1 2 *(please circle dose required)*

(note those with hx of smallpox vaccination should receive only 1 dose of Imvamune)

Eligibility: *please check all that apply*

- □ Two-Spirit, non-binary, transgender, cisgender, intersex, or gender-queer individuals who self-identify or have sexual partners who self-identify as belonging to the gay, bisexual, pansexual and other men who have sex with men (gbMSM) community AND at least one of the following:
  - Had a confirmed sexually transmitted infection (STI) within the last year;
  - Have or are planning to have two or more sexual partners or are in a relationship where at least one of the partners may have other sexual partners;
  - Have attended venues for sexual contact (e.g., bathhouses, sex clubs) recently or may be planning to, or who work/volunteer in these settings;
  - Have had anonymous sex (e.g., using hookup apps) or may be planning to; and/or
  - Are a sexual contact of an individual who engages in sex work.

- □ Individuals who self-identify as engaging in sex work or are planning to, regardless of self-identified sex or gender.

- □ Research laboratory employees working directly with replicating orthopoxviruses.

- □ Household and/or sexual contacts of those identified for pre-exposure vaccination eligibility in parts (1) and (2) above **AND** who are moderately to severely immunocompromised or pregnant.

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THU STAFF TO COMPLETE **PAN Req # _____**

PHU Staff Name and Signature (screening validation completed):

NAME: _____ DATE: _____ SIGNATURE: _____

HEALTH CARE PROVIDER PICK UP	Date:_____ Signature:_____