Healthcare Provider Vaccine Requisition Form
School – High Risk

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 eligibility criteria
High Risk Immunization Reporting Form must be completed and faxed following vaccine administration

Name of Facility, Physician, or Practice:		
Date:	Phone Number:	Fax Number:

MENINGOCOCCAL C-ACYW135 (MENACTRA®)
6571-3360-0

Name (First & Last): _____

DOB (YYYY/MM/DD): _____

DATE ADMINISTERED: _____

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

Eligibility – Age 9 months to 55 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 deficiency
- ☐ HIV

Or

- ☐ Grade 7 – 12 students

HUMAN PAPILLOMAVIRUS (HPV-9)
6571-3390-0

Name (First & Last): _____

DOB (YYYY/MM/DD): _____

DATE ADMINISTERED: _____

☐ Two-Dose Series (Age 9 – 14 yrs)

☐ Three-Dose Series (Immunocompromised and immunocompetent HIV-infected individuals or those age ≥ 15 yrs)
Dose # 1 2 3
(please circle dose required)

Eligibility

- ☐ All Healthy Grade 7 students (who remain eligible to grade 12)
- ☐ Men who have sex with men – ages 9 – 26 Years

***HAEMOPHILUS INFLUENZAE* TYPE B (ACT-HIB®)**
6571-3255-0

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.*

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)

MENINGOCOCCAL B (BEXSERO®)
6571-3314-0

Name (First & Last): _____

DOB (YYYY/MM/DD): _____

DATE ADMINISTERED: _____

Current Dose # 1 2 3 4
(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 deficiency
- □ Cochlear implant recipient (pre/post implant)
- □ Acquired complement deficiency
- □ HIV

MENINGOCOCCAL P-ACYW135 (MENOMUNE®)
6571-3327-2

Name (First & Last): _____

DOB (YYYY/MM/DD): _____

DATE ADMINISTERED: _____

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

Eligibility – ≥ 56 years with:
(please check all that apply)

- □ Functional or anatomic asplenia
- □ Complement, properdin, factor D deficiency, or primary antibody deficiency
- □ Cochlear implant recipients (pre/post implant)
- □ Acquired complement deficiency
- □ HIV

PNEUMOCOCCAL-C-13 VALENT (PREVNAR®13)
6571-2202-5

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.*
of the current Publicly Funded Immunization Schedule for vaccine intervals.

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.*

***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*

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

- □ Hematopoietic stem cell transplant (HSCT)* (3 doses)
- □ HIV (1 dose)
- □ Immunosuppresive condition including (1 dose):
  - Asplenia
  - Sickle cell disease or other hemogloinopathies
  - Cogenital immunodeficiencies 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
  - Immunosuppressive therapy including use of long-term corticosteroids, chemotherapy, radiation therapy, post-organ transplant therapy, biologic and non-biologic immunosuppressive therapies for rheumatologic and other inflammatory diseases
  - Malignant neoplasms including leukemia and lymphoma
  - Solid organ or islet cell transplant (candidate or recipient)

***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*

PNEUMOCOCCAL-P-23 VALENT (PNEUMOVAX®23)
6571-4010-2

Name (First & Last): _____

DOB (YYYY/MM/DD): _____

DATE ADMINISTERED: _____

Dose # 1 2*
(please circle dose required)

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

Note: *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.

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*
- □ Chronic renal disease
- □ Chronic renal failure or nephrotic syndrome *****
- □ Asplenia, splenic dysfunction, sickle-cell disease or other sickle cell haemoglobinopathy *****
- □ Primary immune deficiency *****
- □ Immunosuppressive condition (e.g. malignant neoplasms)*****
- □ Immunosuppressive therapy *****
- □ HIV *****
- □ Undergoing solid organ or islet cell transplant (candidate or recipient) *****
- □ Undergoing HSCT (candidate or recipient)*
- □ Congenital immunodeficiency involving any part of the immune system *****

HEPATITIS A (AVAXIM®/HAVRIX®)
6571-3257-0 (adult)
6571-3256-0 (paediatric)

Name (First & Last): _____

DOB (YYYY/MM/DD): _____

DATE ADMINISTERED: _____

Dose # 1 2
(please circle dose required)

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

HEPATITIS B (RECOMBIVAX HB®/ENGERIX®-B) 6571-3251-0 (paediatric) 6571-3243-0 (adult/adolescent) 6571-3324-1 (renal dialysis) Name (First & Last): _____ DOB (YYYY/MM/DD): _____ DATE ADMINISTERED: _____ Dose # 1 2 3 4 *(please circle dose required)*	**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 or sexual contact of chronic carrier or acute case (3 doses) □ Individuals engaging in intravenous drug use (3 doses) □ Men who have sex with men, individual with multiple sex partners, or history of a sexually transmitted disease (3 doses or 2 doses if 11 – 15 years of 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 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) (3 doses) □ Awaiting liver transplant (3 doses) or □ Grade 7 Students (who remain eligible to Grade 8) (2 dose series)

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

PHU Staff Name and Signature (screening validation completed):

NAME: _____ **DATE: _____** **SIGNATURE: _____**

HEALTH CARE PROVIDER PICK UP	Date: _____ Signature: _____