North Bay Parry Sound District
Health Unit
Bureau de santé
du district de North Bay-Parry Sound

Publicly Funded **HIGH RISK** Vaccine Order Form

Please fax all pages of this form to the Health Unit at 705-474-0510 Attention: Yvette Lavigne

______________________ Name of Facility / Physician / office

______________________ year/month/day

______________________ Phone Number

Vaccine Requested	Eligibility Criteria
Haemophilus influenza type b (ACT-HIB) Client Name: ______________________ Client DOB: ______________________ year/month/day Client Health Card Number: ______________ Please check the appropriate box for dose being requested: ☐1 ☐2 ☐3 Date of previous dose(s): ☐1 ______________ ☐2 ______________	**Eligibility - clients ≥ 5 years with:** (check all that apply) ☐ Hematopoietic stem cell transplant (HSCT) recipient **(3 doses)** ☐ Functional or anatomical asplenia **(1 dose)** ☐ Immunocompromised related to disease of 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) Client Name: ______________________ Client DOB: ______________________ year/month/day Client Health Card Number: ______________ Please check the appropriate box for dose being requested: ☐1 ☐2 ☐3 ☐4 Date of previous dose(s): ☐1 ______________ ☐2 ______________ ☐3 ______________	**Eligibility - clients age 2 months to 17 years with:** (check all that apply) ☐ Acquired complement deficiencies ☐ Functional or anatomical asplenia ☐ Cochlear implant recipient (pre/post implant) ☐ Complement, properdin, factor D deficiency, or primary antibody deficiency ☐ HIV
Meningococcal C-ACYW135 (Menactra) Client Name: ______________________ Client DOB: ______________________ year/month/day Client Health Card Number: ______________ Please check the appropriate box for dose being requested: ☐1 ☐2 ☐3 ☐4 ☐ booster Date of previous dose(s): ☐1 ______________ ☐2 ______________ ☐3 ______________ ☐4 ______________	**Eligibility - clients with:** (check all that apply) ☐ Acquired complement deficiencies ☐ Functional or anatomical asplenia ☐ Cochlear implant recipient (pre/post implant) ☐ Complement, properdin, factor D deficiency, or primary antibody deficiency ☐ HIV
Pneumococcal-C-13 (Prevnar 13) Client Name: ______________________ Client DOB: ______________________ year/month/day Client Health Card Number: ______________ Dose Requested: ■ 1	**Eligibility - clients ≥ 50 years with:** (check all that apply) ☐ Hematopopietic stem cell transplant **(3 doses)** ☐ HIV **(1 dose)** ☐ Immunosuppressive conditions including: **(1 dose)** ○ Asplenia ○ Congenital 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 ○ HIV ○ HSCT recipient ○ 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 ○ Sickle cell disease or other hemoglobinopathies ○ Solid organ or islet cell transplant (candidate or recipient)

Pneumococcal-P-23 Valent (Pneumovax 23)

Client Name: _______________________________

Client DOB: _______________________________
year/month/day

Client Health Card Number: __________________

Please check the appropriate box for dose being requested:

☐1 ☐2

Eligibility - clients age 2 to 64 years with: (check all that apply)

☐ Asplenia, splenic dysfunction
☐ Chronic cardiac disease
☐ Chronic cerebrospinal fluid leak
☐ Cochlear implant recipients (pre/post implant)
☐ Congenital immunodeficiency involving any part of the immune system
☐ Diabetes mellitus
☐ HIV
☐ Immunosuppressive therapy including use of long-term systematic corticosteroid, chemotherapy, radiation therapy, post-organ transplant therapy, certain anti-rheumatic drugs and other immunosuppressive therapy
☐ Chronic liver disease (including hepatitis B and C and hepatic cirrhosis)
☐ Malignant neoplasms, including leukemia and lymphoma
☐ Chronic renal disease, including nephrotic syndrome
☐ Chronic respiratory disease (excluding asthma, unless treated with high dose corticosteroid therapy)
☐ Sickle-cell disease or other sickle cell haemoglobinopathies
☐ Solid organ or islet cell transplant (candidate or recipient)
☐ Chronic neurologic condition that may impair clearance of oral secretions
☐ HSCT (candidate or recipient)
☐ Resident of a nursing home, home for the aged, chronic care facility/ward

Hepatitis A (Avaxim / Havrix/Vaqta)

Client Name: _______________________________

Client DOB: _______________________________
year/month/day

Client Health Card Number: __________________

Please check the appropriate box for dose being requested:

☐ Pediatric dose Dose # ☐1 ☐2
☐ Adult dose Dose # ☐1 ☐2

Date of previous dose(s):
☐1 _______________________
☐2 _______________________

Eligibility - clients ≥ 1 year with: (check all that apply)

☐ Intravenous drug use
☐ Chronic liver disease, including hepatitis B and C
☐ Men who have sex with men

Hepatitis B (Recombivax HB / Engerix-B)

Client Name: _______________________________

Client DOB: _______________________________
year/month/day

Client Health Card Number: __________________

Please check the appropriate box for dose being requested:

☐Pediatric dose Dose # ☐1 ☐2 ☐3 ☐4
☐Adult dose Dose # ☐1 ☐2 ☐3 ☐4
☐Dialysis dose Dose # ☐1 ☐2 ☐3 ☐4

Date of previous dose(s):
☐1 _______________________
☐2 _______________________
☐3 _______________________

Eligibility - clients ≥ 0 year with: (check all that apply)

☐ Child < 7 years old whose family has immigrated from a country of high prevalence for HBV and who may be exposed to HBV carriers through their extended family **(3 doses)**
☐ Household or sexual contact of chronic carrier or acute case **(3 doses)**
☐ Infant born to HBV positive carrier mother:
- ○ Premature infant weighing <2,000 grams at birth **(4 doses)**
- ○ Premature infant weighing ≥ 2,000 grams at birth and full/post term infant **(3 doses)**

☐ Intravenous drug use **(3 doses)**
☐ Chronic liver disease including hepatitis B and C **(3 doses)**
☐ Awaiting liver transplant **(2nd and 3rd doses only)**
☐ Men who have sex with men, individual with multiple sex partners or history of a sexually transmitted disease **(3 doses)**
☐ Needle stick injury in a non-health care setting **(3 doses)**
☐ Renal dialysis or disease requiring frequent receipt of blood products (e.g. haemophilia) **(2nd and 3rd doses only)**

Human Papillomavirus (Gardasil)

Client Name: _______________________________________

Client DOB: _______________________________________
year/month/day

Client Health Card Number: __________________________

Please check the appropriate box for dose being requested:

☐1 ☐2 ☐3

Date of previous dose(s):
☐1 _______________________
☐2 _______________________

Eligibility – Men having sex with men, who are 26 years of age or younger

HPV 4

☐ MSM who started their vaccine series with HPV 4 and have not finished the series.

O R

HPV 9

☐ MSM (aged 9-26 who have not previously received HPV 4)

Additional Comments:

For Health Unit Use only:

Reviewed by:	☐ Approved	☐ Not approved
Additional Comments		