

Publicly Funded High Risk Vaccine Order Form

	: Health @ 519-376-7782 . All informa pased on Publicly Funded Immunizatio	tion must be filled out for each vaccine ordered. on Schedule – June 2022 (Table 3).	
Name of Facility, Physician, or Practice:	·	Requisition ID:	
Date:	Phone Number:	(Public Health Use Only) Fax Number:	
Haemophilus influenzae type b (Act-HIB®)	Eligibility – ≥ 5 years with: (please	** **	
Client's Name:			
DOB (YYYY/MM/DD):	 □ Bone marrow or solid organ transplant recipients (1 dose) □ Cochlear implant recipients (pre/post implant) (1 dose) 		
Dose # 1 2 3 (please circle dose required)	☐ Hematopoietic stem cell transplant (HSCT) recipients (3 doses)		
Date of Last Dose (If Applicable):(YYYY/MM/DD)	☐ Immunocompromised individuals related to disease or therapy (1 dose)		
* HSCT recipients are eligible for 3 doses. All other	☐ Lung transplant recipients (1 dose)		
eligible conditions receive only 1 dose. See Table 9	☐ Primary antibody deficient		
of the Publicly Funded Immunization Schedule –			
June 2022 for vaccine intervals.	Note: High risk children 5 to 6 years of age who require DTaP-IPV and Hib may receive DTaP-IPV-Hib instead of Hib.		
Hepatitis A (Avaxim®/Havrix®)	Eligibility - ≥ 1 year with: (please check all that apply)		
Client's Name:	☐ Intravenous drug use		
DOB (YYYY/MM/DD):	☐ Liver disease (chronic), inc	luding hepatitis B and C	
Dose # 1 2 (please circle dose required) Date of Last Dose (If Applicable):	☐ Men who have sex with m	en	
(YYYY/MM/DD)			
Hepatitis B (Recombivax HB®/Engerix®-B)	Eligibility – ≥ 0 years with:	(please check all that apply)	
		se families have immigrated from countries of high	
Client's Name:	prevalence for HBV and w	ho may be exposed to HBV carriers through their extended	
DOB (YYYY/MM/DD): Dose# 1 2 3 4 Booster (please circle dose	families (3 doses)		
required)		tacts of chronic carriers and acute cases (3 doses)	
Date of Last Dose (If Applicable):	☐ History of a sexually trans		
(YYYY/MM/DD)	☐ Infants born to HBV-positi		
		ighing <2,000 gms at birth (4 doses)	
	☐ Intravenous drug use (3 do	ighing ≥2,000 gms at birth & full/post term infants (3 doses)	
		luding hepatitis C (3 doses)	
	☐ Awaiting liver transplants		
	☐ Men who have sex with m		
	☐ Multiple sex partners (3 de	oses)	
	□ Needle stick injuries in a n	on-health care setting (3 doses)	
		with diseases requiring frequent receipt of blood products	
HPV9 (Gardasil 9®)	(e.g. haemophilia) (2nd an	d 3rd doses only) years (Eligibility criteria expanded to incl males born 1993	
Client's Name:	through 1997 until 2024-12-31) wh		
DOB (YYYY/MM/DD):	☐ Have sex with men		
Dose # 1 2 3 (please circle dose required)			
Date of Last Dose (If Applicable):(YYYY/MM/DD)			
Meningococcal B(Bexsero®)	Eligibility – 2 months to 17 years (*	Eligibility criteria expanded to incl those born 2002	
Client's Name:	through 2006 until 2024-12-31) with: (please check all that apply)		
DOB (YYYY/MM/DD):		iciencies (e.g., receiving eculizumab)	
Dose # 1 2 3 4 (please circle dose required) Date of Last Dose (If Applicable):	☐ Asplenia (functional or and		
(YYYY/MM/DD)	☐ Cochlear implant recipient		
		actor D or primary antibody deficiencies	
Meningococcal-C-ACYW-135	☐ HIV Fligibility = 9 months = 55 years (*F	ligibility criteria expanded to incl. those born 1964	
(Menactra, Menveo or Nimenrix)	through 1968 until 2024-12-31) wit		
Client's Name:	☐ Acquired complement def	iciencies (e.g., receiving eculizumab)	
DOB (YYYY/MM/DD):	☐ Asplenia (functional or and	atomic)	
Dose # 1 2 3 4 Booster (please circle dose required) Date of Last Dose (If Applicable):	□ Cochlear implant recipient	s (pre/post implant)	
(YYYY/MM/DD)	☐ Complement, properdin, f	actor D or primary antibody deficiencies	
	□ HIV		
Meningococcal C-ACYW135 (Menactra, Menveo or Nimenrix)	Eligibility – ≥ 56 years with:	(please check all that apply)	
Client's Name:		iciencies (e.g., receiving eculizumab)	
DOB (YYYY/MM/DD):	☐ Asplenia (functional or and☐ Cochlear implant recipient		
Dose # 1	-	actor D or primary antibody deficiencies	
		2.1. 2.3. p.m.s., andbody deficiences	
MMR	Eligibility –6-11 months (1 dose) wh	10:	
Client's Name:		where disease is a concern	
DOB (YYYY/MM/DD): Dose # 1 2 (please circle dose required)	Note: 2 additional doses are required at ≥1 year of age and at appropriate intervals		
Date of Last Dose (If Applicable):	Eligibility ≥18 years (as a 2 nd dose):		
(YYYY/MM/DD)	☐ If they are health care wor ☐ If they are post-secondary		
		vel to areas where disease is a concern	
	☐ Based on health care prov		
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Uersion Date: January 2024

□ Based on hearth care provider's cliffical juugement

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Name of Facility, Physician, or Practice:		Requisition ID:	
		(Public Health Use Only)	
Date:	Phone Number:	Fax Number:	
Pneumococcal-C-13 (Prevnar 13®)	Eligibility – 6 weeks to 6 months (4th d	ose) who:	
Client's Name: DOB (YYYY/MM/DD):		cal-P-23 high risk criteria from #1 -14 of PFISO Table 3	
Dose # 1 2 3 4 (please circle dose required)		Guide recommends that the minimum interval between	
Date of Last Dose (If Applicable):	doses of Pnuemococcal-C-13 be 8 weeks.		
(YYYY/MM/DD)	Eligibility ≥ 50 years (1 or 3 doses) with: (please check all that apply)		
	☐ Asplenia (anatomical or func	tional) (1 dose)	
	☐ Congenital immunodeficienc	ies involving any part of the immune system, incluing B-	
		ty, T-lymphocyte (cell) mediated immunity, complement D deficiencies), or phagocytic functions (1 dose)	
	□ HIV (1 dose)		
	☐ HSCT recipient (3 doses)		
		py including use of long-term corticosteroids,	
	* *	rapy, post-organ-transplant therapy, biologic and certain	
	anti-rheumatic drugs (1 dose	<i>)</i> ng leukemia and lymphoma (1 dose)	
	☐ Malignant neoplasms includi☐ Sickle cell disease or other he		
		plant (candidate or recipient) (1 dose)	
Pneumococcal-P-23 Valent (Pneumovax®23)	Eligibility – 2-64 years (1 dose) with:	(please check all that apply)	
Client's Name:	1. Asplenia (functional or an2. Cardiac disease (chronic)	atomic), spienic dysfunction	
DOB (YYYY/MM/DD):	2. Cardiac disease (chronic)3. Cerebral spinal fluid leak (chronic)	
Dose # 1 2 (please circle dose required)	☐ 4. Cochlear implant recipien		
Date of Last Dose (If Applicable):(YYYY/MM/DD)		unodeficiencies involving any part of the immune	
(YYYY/MINI/DD)		te (humoral) immunity, T-lymphocyte (cell) mediated	
		m (properdin or factor D deficiencies), or phagocytic	
	functions		
	☐ 6. Diabetes mellitus		
	□ 7. HIV		
	_ · · · · · · · · · · · · · · · · · · ·	erapy including use of long-term systemic	
		, radiation therapy, post-organ transplant therapy, and other immunosuppressive therapy	
	_	cluding hepatitis B and C, and hepatic cirrhosis due to any	
	cause	rading reputition build e, and reputite environments due to arry	
	☐ 10. Malignant neoplasms, in	cluding leukemia and lymphoma	
	☐ 11. Renal disease (chronic), i	ncluding nephrotic syndrome	
	☐ 12. Respiratory disease (chro	onic), excluding asthma, except those treated with high-	
	dose corticosteroid therapy		
		her sickle cell haemoglobinopathies	
	_	ansplant (candidate or recipient)	
		hronic) that may impair clearance of oral secretions	
	☐ 16. HSCT (candidate or recip		
	☐ 17. Residents of nursing hon wards	nes, homes for the aged and chronic care facilities or	
	warus		
	Eligibility – ≥ 2 years (as a 2 nd dose) w	ith: (please check all that apply)	
	☐ Asplenia (functional or anato	mic) or sickle cell disease	
	☐ Hepatic cirrhosis		
	□ HIV		
	☐ Immunocompromised relate		
IDV Tdon IDV Td IDV	Renal failure (chronic) or nep	hrotic syndrome	
IPV, Tdap-IPV, Td-IPV Client's Name:	Eligibility – ≥ 18 years who:	nization series against polio and are travelling to areas	
DOB (YYYY/MM/DD):	where polio virus is known o		
Dose # 1	-	ceive a single adult lifetime booster dose of IPV-	
Date of Last Dose (If Applicable):	containing vaccine. The most appropriate vaccine (i.e. IPV, Tdap-IPV or Td-IPV) should be		
(YYYY/MM/DD) Varicella	selected. Fligibility - Those born on or prior to [December 31, 1999 who: (Please check all that apply)	
Client's Name:		adolescents given chronic salicylic acid therapy	
DOB (YYYY/MM/DD):	☐ Are susceptible individuals w		
Dose # 1 2 (please circle dose required)	· ·	entacts of immunocompromised individuals	
Date of Last Dose (If Applicable):	1	eceiving low dose steroid therapy or inhaled / topical	
(YYYY/MM/DD)	steroids	5	
	•	promised individuals (See Canadian Immunization Guide	
	for more information.)		

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