

Renfrew County and

District Health Unit "Optimal Health for All in Renfrew County and District"

PART 1	ART 1 ORGANIZATION INFO (PLEASE COMPLETE ALL FIELDS)								
ORGANIZATION NAME:									
CONTACT:				EMAIL:					
PHONE NU	MBER:			FAX NUMBER:					
PART 2 HIGH-RISK CLIENT INFO (PLEASE COMPLETE ALL FIELDS)									
PART 2 HIGH-RISK CLIENT INFO (PLEASE COMPLETE ALL FIELDS) LAST NAME: FIRST NAME:									
LAST NAME: DATE OF BIRTH:			AGE: GENDER: OHIP:						
PART 3	VACCINE OF	-	GIBILITY CRITE	ERIA THAT APPLY AND SELECT D	OSE # REQUESTED)				
AGENTS (BRAND NAME)		PUBLICLY FUNDED AGE GROUPS	HIGH-RISK ELIGIBILITY CRITERIA			DOSE # REQUESTED			
Hib (Act-Hib®)		≥5 years	 Asplenia (functional or anatomic) (1 dose) Bone marrow or solid organ transplant recipients (1 dose) Cochlear implant recipients (pre/post implant) (1 dose) Hematopoietic stem cell transplant (HSCT) recipients (3) 1			
			 doses) Immunocompromised individuals related to disease or therapy (1 dose) Lung transplant recipients (1 dose) 			<u></u> 2			
			 Primary a Note: Hig IPV and H 	<u> </u>					
HA (Havrix® or Vaqta®)		≥1 year	 Intravenous drug use 			○ 1			
			 Liver disease (chronic), including hepatitis B and C Men who have sex with men (MSM) 			<u> </u>			
			countries exposed t o Househol	ld and sexual contacts of chronic	who may be	<u></u> 1			
HB	-B® or	or	cases (3 c o History of o Infants bo – pren dose	<u> </u>					
○ (Engerix-B [®] or Recombivax HB [®]		≥0 years	– pren full/j	○ 3					
\smile ·	nbivax HB resentation®)		 Intraveno Liver dise Awaiting Men who Multiple s 	<u></u> 4					
			o On renal	tick injuries in a non-health care dialysis or those with diseases r f blood products (e.g., haemoph ly)	equiring frequent	⊖ Booster			

PART 3 (CONT.) VACCINE ORDER (CHECK ELIGIBILITY CRITERIA THAT APPLY AND SELECT DOSE # REQUESTED)						
AGENTS (BRAND NAME)	PUBLICLY FUNDED AGE GROUPS	HIGH-RISK ELIGIBILITY CRITERIA	DOSE # REQUESTED			
HPV-9 (Gardasil-9®)	Males 9 to 26 years	 Men who have sex with men 	○ 1○ 2○ 3			
4CMenB (Bexsero®)	2 months to 17 years	 Acquired complement deficiencies (e.g., receiving eculizumab) Asplenia (functional or anatomic) Cochlear implant recipients (pre/post implant) Complement, properdin, factor D or primary antibody deficiencies Human Immunodeficiency Virus (HIV) 	 ○ 1 ○ 2 ○ 3 ○ 4 			
Men-C-ACYW-135 (Nimenrix® or Menactra®)	9 months to 55 years ≥56 years	 Acquired complement deficiencies (e.g., receiving eculizumab) Asplenia (functional or anatomic) Cochlear implant recipients (pre/post implant) Complement, properdin, factor D or primary antibody deficiencies Human Immunodeficiency Virus (HIV) 	 ○ 1 ○ 2 ○ 3 ○ 4 ○ Booster 			

PART 4	VACCINE ADMINISTRATION (ONCE VACCINE(S) ADMINISTERED, COMPLETE PART 4 AND SUBMIT TO RCDHU)							
AGENTS (BRAND NAME)		DOSE # DISPENSED	LOT #	EXPIRY DATE	DATE GIVEN (YYYY/MM/DD)	GIVEN BY		PANORAMA ENTRY
AGENT: BRAND NAME:							Х	
AGENT: BRAND NAME:							USE ONLY	
AGENT: BRAND NAME:							RCDHU U	
AGENT: BRAND NAME:							RC	
AGENT: BRAND NAME:								

PART 4 ACCOUNTABILITY STATEMENT

By submitting this order, I verify on behalf of the practice that the refrigerator storing publicly funded vaccines, at the location listed above, maintains temperatures between +2.0°C to +8.0°C; meets <u>MOHLTC Vaccine Storage and Handling</u> <u>Protocols and Guidelines</u>; maximum, minimum, and current temperatures are recorded at least twice daily. Upon vaccine pick-up, I will have the necessary materials for the safe transport of publicly funded vaccines including properly conditioned hard sided, insulated container, digital temperature monitoring device, and appropriate packaging material. NAME: SIGNATURE: DATE (YYYY/MM/DD):

High-Risk vaccine orders must be placed separately. High-Risk Vaccine Order form must be completed in full and preferably emailed to <u>vaccineorders@rcdhu.com</u> or faxed to 613-735-3067 (Attn: Vaccine Orders).

Of note: for urgent high risk vaccine orders, please call the Inventory cellphone at 343-544-6970.