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

High-Risk Vaccine Order Form

FOR HEALTH CARE PROVIDERS

PART 1	**ORGANIZATION INFO** (PLEASE COMPLETE ALL FIELDS)
ORGANIZATION NAME:	
CONTACT:	EMAIL:
PHONE NUMBER:	FAX NUMBER:

PART 2	**HIGH-RISK CLIENT INFO** (PLEASE COMPLETE ALL FIELDS)		
LAST NAME:		PREVIOUS LAST NAME:	
FIRST NAME:	DATE OF BIRTH:	AGE:	OHIP:
PHONE NUMBER:	ADDRESS:		

PART 3 **VACCINE ORDER** (CHECK ELIGIBILITY CRITERIA THAT APPLY AND SELECT DOSE # 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 doses) ○ Immunocompromised individuals related to disease or therapy (1 dose) ○ Lung transplant recipients (1 dose) ○ Primary antibody deficiencies (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	◯ 1 ◯ 2 ◯ 3
HA (Havrix® or Vaqta®)	≥1 year	○ Intravenous drug use ○ Liver disease (chronic), including hepatitis B and C ○ Men who have sex with men (MSM)	◯ 1 ◯ 2
HB ◯ (Engerix-B® or Recombivax HB®) ◯ (Recombivax HB Dialysis Presentation®)	≥0 years	○ Children <7 years old whose families have immigrated from countries of high prevalence for HBV and who may be exposed to HBV ○ Household and sexual contacts of chronic carriers and acute cases (3 doses) ○ History of a sexually transmitted disease (3 doses) ○ Infants born to HBV-positive carrier mothers: – premature infants weighing <2,000 grams at birth 4 doses) – premature infants weighing ≥2,000 grams at birth and full/post term infants (3 doses) ○ Intravenous drug use (3 doses) ○ Liver disease (chronic), including hepatitis C (3 doses) ○ Awaiting liver transplants (2nd and 3rd doses only) ○ Men who have sex with men (3 doses) ○ Multiple sex partners (3 doses) ○ Needle stick injuries in a non-health care setting (3 doses) ○ On renal dialysis or those with diseases requiring frequent receipt of blood products (e.g., haemophilia) (2nd and 3rd doses only)	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ Booster

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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
RSV (Abrysvo® or Arexvy)	60+	○ Residents of LTCH, Elder Care Lodges or RHs ○ Inpatients receiving ALC ○ Hemodialysis or Peritoneal dialysis ○ Solid organ or stem cell transplants ○ Homelessness ○ First Nations, Inuit or Metis persons	◯ 1

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 MOHLTC Vaccine Storage and Handling Protocols and Guidelines; maximum, minimum, and current temperatures are recorded at least twice daily.

NAME:	SIGNATURE:	DATE (YYYY/MM/DD):

** Please report any/all doses given on page 3 **

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All High-Risk orders must be completed in full and **preferably** emailed to vaccineorders@rcdhu.com or faxed to 613-735-3067 (Attn: Vaccine Orders).

	VACCINE ADMINISTRATION (ONCE VACCINE(S) ADMINISTERED, COMPLETE PART 4 AND SUBMIT TO RCDHU)

DATE GIVEN (YYYY/MM/DD)	**GIVEN BY**	***RCDHU USE ONLY***			
		AGENTS (BRAND NAME)	**DOSE # DISPENSED**	**LOT #**	**EXPIRY DATE**
		AGENT: BRAND NAME:			
		AGENT: BRAND NAME:			
		AGENT: BRAND NAME:			

Of note: for urgent high-risk vaccine orders, please call the Immunization Intake Line at 613-732-9636