Publicly Funded High Risk Vaccine Order Form

Fax completed form to Grey Bruce Public Health @ **519-376-7782**. All information must be filled out for each vaccine ordered.
High risk eligibility criteria based on **Publicly Funded Immunization Schedule – June 2022** (Table 3).

Name of Facility, Physician, or Practice:		**Requisition ID:** (Public Health Use Only)
Date:	**Phone Number:**	**Fax Number:**

Haemophilus influenzae type b (Act-HIB®)

Client's Name: _____
DOB (YYYY/MM/DD):_____
Dose # 1 2 3 *(please circle dose required)*
Date of Last Dose (If Applicable):_____
(YYYY/MM/DD)

** HSCT recipients are eligible for 3 doses. All other eligible conditions receive only 1 dose. See Table 9 of the Publicly Funded Immunization Schedule – June 2022 for vaccine intervals.*

Eligibility – ≥ 5 years with: *(please check all that apply)*

- ☐ 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 (1 dose)
- ☐ Primary antibody deficiencies (1 dose)

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®)
Client's Name: _____
DOB (YYYY/MM/DD):_____
Dose # 1 2 *(please circle dose required)*
Date of Last Dose (If Applicable): _____
(YYYY/MM/DD)

Eligibility – ≥ 1 year who meet one or more of the following: *(please 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's Name: _____
DOB (YYYY/MM/DD):_____
Dose# 1 2 3 4 Booster *(please circle dose required)*
Date of Last Dose (If Applicable): _____
(YYYY/MM/DD)

Eligibility – ≥ 0 years who meet one or more of the following: *(please check all that apply)*

- ☐ Children <7 years old whose families have immigrated from countries of high prevalence for HBV and who may be exposed to HBV carriers through their extended families (3 doses)
- ☐ 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 gms at birth (4 doses)
  - ☐ premature infants weighing ≥2,000 gms at birth & 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)

HPV9 (Gardasil 9®)
Client's Name: _____
DOB (YYYY/MM/DD):_____
Dose # 1 2 3 *(please circle dose required)*
Date of Last Dose (If Applicable): _____
(YYYY/MM/DD)

Eligibility – Males age 9 years to 26 years (<u>Eligibility criteria expanded to incl males born 1993 through 1997 until 2024-12-31)</u> who:

- ☐ Have sex with men

Meningococcal B(Bexsero®)
Client's Name: _____
DOB (YYYY/MM/DD):_____
Dose # 1 2 3 4 *(please circle dose required)*
Date of Last Dose (If Applicable):_____
(YYYY/MM/DD)

Eligibility – 2 months to 17 years who meet one or more of the following <u>(*Eligibility criteria expanded to incl those born 2002 through 2006 until 2024-12-31)</u> with:
(please check all that apply)

- ☐ 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
- ☐ HIV

Meningococcal-C-ACYW-135
(Menactra, Menveo or Nimenrix)
Client's Name: _____
DOB (YYYY/MM/DD):_____
Dose # 1 2 3 4 Booster *(please circle dose required)*
Date of Last Dose (If Applicable):_____
(YYYY/MM/DD)

Eligibility – 9 months – 55 years who meet one or more of the following <u>(*Eligibility criteria expanded to incl. those born 1964 through 1968 until 2024-12-31)</u> with:
(please check all that apply)

- ☐ 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
- ☐ HIV

Meningococcal C-ACYW135
(Menactra, Menveo or Nimenrix)
Client's Name: _____
DOB (YYYY/MM/DD):_____
Dose # 1

Eligibility – ≥ 56 years who meet one or more of the following: *(please check all that apply)*

- ☐ 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
- ☐ HIV

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Date:	**Phone Number:**	**Fax Number:**

MMR
Client's Name: _____
DOB (YYYY/MM/DD):_____
Dose # 1 2 *(please circle dose required)*
Date of Last Dose (If Applicable):_____
(YYYY/MM/DD)

Eligibility –6-11 months (1 dose) who meet one or more of the following:

- ☐ Will be traveling to areas where disease is a concern

Note: *2 additional doses are required at ≥1 year of age and at appropriate intervals*

Eligibility -- ≥18 years (as a 2nd dose):

- ☐ If they are health care workers
- ☐ If they are post-secondary students
- ☐ If they are planning to travel to areas where disease is a concern
- ☐ Based on health care provider's clinical judgement

Pneumococcal-C-20 (Prevnar 20™)
Client's Name: _____
DOB (YYYY/MM/DD):_____
Dose # 1 2 3 4 *(please circle dose required)*
Date of Last Dose (If Applicable):_____
(YYYY/MM/DD)

Eligibility – 6 weeks and older who meet one of the following criteria *(# of doses depends on age – see age appropriate eligibility chart from MOHLTC):*

- ☐ Asplenia (anatomical or functional), splenic dysfunction
- ☐ Congenital immunodeficiencies involving any part of the immune system, incluing B-lympocyte(humoral) immunity, T-lymphocyte (cell) mediated immunity, complement system (properdin or factor D deficiencies), or phagocytic functions
- ☐ HIV
- ☐ Hematopoetic stem cell transplant (HSCT) (recipient)
- ☐ Immunocompromising therapy including use of long-term corticosteroids, chemotherapy, radiation therapy, post-organ-transplant therapy, biologic and certain anti-rheumatic drugs
- ☐ Malignant neoplasms including leukemia and lymphoma
- ☐ Sickle cell disease or other hemoglobinopathies
- ☐ Solid organ or islet cell transplant (recipient)
- ☐ Chronic cardiac disease
- ☐ Chronic cerebral spinal fluid leak
- ☐ Diabetes mellitus
- ☐ Chronic liver disease, including hepatitis B and C
- ☐ Hepatic chirrhosis due to any cause
- ☐ Chronic renal disease, including nephrotic syndrome
- ☐ Chronic respiratory disease, excluding asthma, excecpt those treated with high-dose cortisocsteroid therapy
- ☐ Chronic neurologic conditions that may impair clearance of oral secretions
- ☐ Residents of nursing homes, homes for the aged, chronic care facilities or wards
- ☐ Cochlear implant (pre/post implant) – only for those <65yrs of age

IPV, Tdap-IPV, Td-IPV
Client's Name: _____
DOB (YYYY/MM/DD):_____
Dose # 1
Date of Last Dose (If Applicable): _____
(YYYY/MM/DD)

Eligibility – ≥ 18 years who:

- ☐ Have completed their immunization series against polio and are travelling to areas where polio virus is known or suspected to be circulating.

Note: *Travellers are eligible to receive a single adult lifetime booster dose of IPV-containing vaccine. The most appropriate vaccine (i.e. IPV, Tdap-IPV or Td-IPV) should be selected.*

Varicella
Client's Name: _____
DOB (YYYY/MM/DD):_____
Dose # 1 2 *(please circle dose required)*
Date of Last Dose (If Applicable): _____
(YYYY/MM/DD)

Eligibility – Those born on or prior to December 31, 1999 who meet one or more of the following: *(Please check all that apply)*

- ☐ Susceptible children and adolescents given chronic salicylic acid therapy
- ☐ Susceptible individuals with cystic fibrosis
- ☐ Household contacts of immunocompromised individuals
- ☐ Susceptible individuals receiving low dose steroid therapy or inhaled / topical steroids
- ☐ Susceptible immunocompromised individuals (See Canadian Immunization Guide for more information.)