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Biological Depot - Public Health, Central Zone

7 Mellor Avenue, Unit 5, Dartmouth, NS B3B 0E8

##### Fax or Email to: (902) 481-5923

**PublicHealthVaccineOrders@nshealth.ca**

# Requisition for High Dose Influenza Vaccine 2018-2019 for Residents ≥65 in Long Term Care Facilities

# Product Requisition ID #

**Full Name** and **Address** where HD Fluzone for LTCF/RCF will be **shipped/stored**:

# Completed By: (Please Print)

Name:

Telephone:

Fax:

Date:

Doctor or Pharmacist order for LTCF/RCF

**Mode of Delivery:**  **Deliver via Med Express**. Please contact Med Express to see if they deliver to your

area and applicable charges

**Pick-up** (Public Health will contact you to arrange pick-up when order is ready)

***\*\* Vaccines will not be released without a hard sided cooler with lid, packing material and ice pack\*\****

Given the burden of influenza A (H3N2) disease and evidence of better efficacy in adults aged 65 years and older, it is expected that Fluzone® High-Dose will provide superior protection compared with the standard dose influenza vaccine. NSHA recommends that dosing schedules be verified with the current Canadian Immunization Guide and product monographs.

For the 2018-19 season, Nova Scotia Department of Health & Wellness is offering Fluzone® High-Dose for residents of long-term care facilities aged 65 years and older.

This form is for ordering publicly funded seasonal High Dose Influenza for residence greater than or equal to 65 years of age.

* Order vaccine on a biweekly basis
* **It is required to Fill “Doses on Hand”.**

**Required Information**: # of licensed beds ≥ 65 years old: \_\_\_\_\_\_\_\_

***\*\*Product must be stored in a temperature monitored refrigerator that is kept between 2-8***˚***C\*\****

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| --- | --- | --- | --- | --- |
| Production Description | Doses per package | Doses on Hand  \*REQUIRED\* | Doses Ordered | Doses Filled |
| High Dose Influenza Vaccine for 65 years and older | 10 |  |  |  |

Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| Do not complete this area until Please Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Vaccine is received from Public Health.  Thank you Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Vaccine Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |