Requisition for Publicly Funded Vaccine – Free Issue

<table>
<thead>
<tr>
<th>COMPLETED BY: (required - Please Print)</th>
<th>Name and Address of Physician/Medical Clinic: (required)</th>
<th>Delivered to Hants Community Hospital for pick up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
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<tr>
<td>Telephone:</td>
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<td>Fax:</td>
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<td>Date:</td>
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Request for High Risk Patients

Mode of Delivery - Deliver via courier to Hants Community Hospital every 2nd week

- This form is for ordering non routine vaccines for clients with high risks conditions as per the Nova Scotia Immunization Manual.
- Non-routine vaccine requests require Public Health approval

Patient Eligibility

Last Name: _____________________________  First Name: _____________________________

DOB: _____________________________  PMI #: _____________________________

Reason (check all that applies):
- Medical indication
- Specify _____________________________
- Hepatitis C program
- Specify _____________________________
- Case contact
- Specify _____________________________
- Risk Behaviour
- Specify _____________________________
- Other
- Specify _____________________________

Vaccine Requested

1. Immunizing Agent/Product: _____________________________  Doses Required: __________  Paediatric ☐  Adult ☐ (✓ if applicable)

Has vaccine been requested for this client before?  Y ☐  N ☐

2. Immunizing Agent/Product: _____________________________  Doses Required: __________  Paediatric ☐  Adult ☐ (✓ if applicable)

Has vaccine been requested for this client before?  Y ☐  N ☐

3. Immunizing Agent/Product: _____________________________  Doses Required: __________  Paediatric ☐  Adult ☐ (✓ if applicable)

Has vaccine been requested for this client before?  Y ☐  N ☐

Any further directions: ____________________________________________

Public Health Office Use

Approved By: _____________________________  Provider #: _____________________________

Date: _____________________________  1. Product #: __________  Lot: __________  Doses: __________

Comment: _____________________________  2. Product #: __________  Lot: __________  Doses: __________

Filled By: _____________________________  Date: _____________________________  3. Product #: __________  Lot: __________  Doses: __________