Interior Health

REFERRAL TO PUBLIC HEALTH ADULT IMMUNIZATION AND / OR TUBERCULOSIS SCREENING

Patient Name *(last)* _____

(first) _____

DOB *(dd / mmm / yyyy)* _____

PHN _____ MRN _____

Account / Visit # _____

IH USE ONLY

Patient Demographics

Patient Name *(last / first)* _____

Date of Birth *(dd / mmm / yyyy)* _____ PHN _____

Phone _____ Email _____

Address _____

Immunizations

☐ Assess this patient for all necessary adult immunizations

☐ Live virus vaccines – if Registered Nurse (RN) working in Public Health recommends, RN will send an approval form to the Most Responsible Practitioner (MRP) separately

Comments: _____

Clients may be offered all publicly funded vaccines for which they are eligible, as per the BC Immunization Manual.

Relevant Clinical Information (see page 2 for additional workspace if needed)

☐ Bleeding disorders
☐ Cochlear implant
☐ Chronic heart / lung disease
☐ Chronic kidney disease
MRP to order Hepatitis B Serology markers
- HBsAg
- Anti-HBs
- Anti-HBc Total

☐ Chronic liver disease
☐ Cerebrospinal fluid leak
☐ Cystic fibrosis
☐ Immune suppressive therapy
Include name of medication and the start / stop date(s)
☐ Hematopoietic stem cell transplant (HSCT)

☐ Hepatitis B or C
☐ HIV
☐ Malignancies / cancers
☐ Neurologic disorders
☐ Solid organ transplant
☐ Asplenia (functional or anatomic)
☐ Diabetes

☐ Other (describe): _____

Indicate if this referral is time sensitive (e.g., booked surgery, starting immune suppressive treatment) and specify time frame: _____

TB Screening Please indicate all that are applicable:

☐ Diagnosis of medical condition (state condition)
☐ HIV
☐ Pre-medication initiation
☐ Starting immune suppressive treatment
☐ Symptomatic for tuberculosis (TB) (state signs and symptoms)
☐ Transplant recipient / donor
☐ _____

☐ Other immune compromising condition(s) (list): _____

Practitioner Notes

Most Responsible Practitioner

Preferred method of communication: _____

Phone _____ Email _____

Date (dd / mmm / yyyy)	Time (24 hour)	Printed Name	Signature	Initials	Designation / College ID #

Permanent part of the health record

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IH USE ONLY

This page to be completed by RN working in Public Health.

Health History	**Comments / Notes**	**Action** (if needed)
Documented immunization history review complete? ☐ Yes ☐ No		
Serology results:		
Chronic illness history:		
Immunocompromising medications, last dose, next dose due. Can the medication be stopped or postponed?		
Recent surgery, transplant, or injury:		
Additional immunization eligibility (risk factors, special considerations, etc.):		
Post-immunization serology required?		
Previous TB Skin test or screening (includes x-ray or Interferon-Gamma Release Assay (IGRA)):		

Date (dd / mmm / yyyy)	Time (24 hour)	Printed Name	Signature	Initials	Designation / College ID #

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