simcoe muskoka
DISTRICT HEALTH UNIT

2021 Special Vaccine Order Form
Fax: 705-684-9834

Date: _____

Facility Name: _____ **Phone #:** _____ **Ext:**____ **Facility Fax #:** _____

Facility Contact: _____ **# of Fridges:** _____ **Type:** ☐ **Bar** ☐ **Domestic** ☐ **Purpose Built**

- Place orders by **Wednesday 3 pm** for pick up the following **Wednesday**
- Orders must include the **previous 4 week** temperature log
- Coolers must be between 2 - 8 ^{O}C for vaccine to be released
- Vaccine order inquiries ext. 8808

➢ ***REFER to the PUBLICLY FUNDED IMMUNIZATION SCHEDULES FOR ONTARIO (January 2021) for # of eligible doses and intervals between doses (product specific tables noted below).***

Initials (First. Last): _____ **DOB (YYYY/MM/DD):** _____

Vaccine Name	Product / Description	Dose # in Series Requested	Eligibility Criteria *(check all that apply)*
Bexsero®	Meningococcal B	Dose: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ***(See Table 14)***	**Age 2 months through 17 years:** ☐ Functional or anatomic asplenia ☐ Complement, properdin, factor D deficiency, or primary antibody deficiency ☐ Cochlear implant recipient (pre/post implant) ☐ Acquired complement deficiency (e.g., receiving eculizumab) ☐ HIV
Menactra®	Meningococcal C-ACYW135	Dose: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Booster ***(See Table 15)***	**Age 9 months through 55 years:** ☐ Functional or anatomic asplenia ☐ Complement, properdin, factor D deficiency or primary antibody deficiency ☐ Cochlear implant recipient (pre/post implant) ☐ Acquired complement deficiency (e.g., receiving eculizumab) ☐ HIV
		Dose: ☐ 1 ***(See Table 15)***	**Age ≥ 56 years:** ☐ Functional or anatomic asplenia ☐ Complement, properdin, factor D deficiency or primary antibody deficiency ☐ Cochlear implant recipients (pre/post implant) ☐ Acquired complement deficiency (e.g., receiving eculizumab) ☐ HIV

Location to be picked up (please check):

☐ **Gravenhurst** ☐ **Huntsville** ☐ **Orillia** **VIM Order #** (for office use only): _____

Vaccine Name	Product / Description	Dose # in Series Requested	Eligibility Criteria *(check all that apply)*
Avaxim® / Havrix® / Vaqta® **Avaxim® Pediatric** **Havrix® Pediatric** **Vaqta® Pediatric**	Hepatitis A	Dose: ☐ 1 ☐ 2 ***(See Table 5)***	**Age ≥ 1 year:** ☐ Chronic liver disease (including hepatitis B and C) ☐ Persons engaging in intravenous drug use ☐ Men who have sex with men
Recombivax HB® / Engerix-B® **Recombivax HB® Pediatric** **Engerix-B® Pediatric**	Hepatitis B ☐ Latex allergy	Dose: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ***(See Table 7)***	**Age ≥ 0 years:** ☐ Infant born to HBV-positive mothers: ○ Premature infant weighing < 2,000 grams at birth (4 doses) ○ Premature infant weighing ≥ 2000 grams at birth and full/post terms infants (3 doses) ☐ Household or sexual contact of chronic carrier or acute cases (3 doses) ☐ Individual engaging in intravenous drug use (3 doses) ☐ Men who have sex with men, individual with multiple sex partners or history of sexually transmitted disease (3 doses) ☐ Needle stick injury in a non-health care setting (3 doses) ☐ Child < 7 years old whose family has immigrated from country of high prevalence for hepatitis B and who may be exposed to hepatitis B carriers through their extended family (3 doses) ☐ Chronic liver disease including hepatitis C (3 doses) ☐ Awaiting liver transplant (2nd and 3rd dose only)
High Dose (Dialysis) Formulation Recombivax HB®	Hepatitis B	Dose: ☐ 1 ☐ 2 ☐ 3 ***(See Table 7)***	**Age ≥ 20 years:** ☐ Chronic renal disease or on dialysis ☐ Chronic liver disease ☐ Individuals awaiting liver transplant ☐ HIV
Gardasil®	HPV	Dose: ☐ 1 ☐ 2 ☐ 3 ***(Table 10 and Table 11)***	**Males 9 to 26 years:** ☐ Men who have sex with men

Location to be picked up (please check):

☐ **Gravenhurst** ☐ **Huntsville** ☐ **Orillia** **VIM Order #** (for office use only): _____

2021-02-10