

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 °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 <u>(check all that apply)</u>
Bexsero®	Meningococcal B	Dose: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 (See Table 14)	<u>Age 2 months through 17 years:</u> <input type="checkbox"/> Functional or anatomic asplenia <input type="checkbox"/> Complement, properdin, factor D deficiency, or primary antibody deficiency <input type="checkbox"/> Cochlear implant recipient (pre/post implant) <input type="checkbox"/> Acquired complement deficiency (e.g., receiving eculizumab) <input type="checkbox"/> HIV
		Dose: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Booster (See Table 15)	<u>Age 9 months through 55 years:</u> <input type="checkbox"/> Functional or anatomic asplenia <input type="checkbox"/> Complement, properdin, factor D deficiency or primary antibody deficiency <input type="checkbox"/> Cochlear implant recipient (pre/post implant) <input type="checkbox"/> Acquired complement deficiency (e.g., receiving eculizumab) <input type="checkbox"/> HIV
Nimenrix®	Meningococcal C-ACYW135	Dose: <input type="checkbox"/> 1 (See Table 15)	<u>Age ≥ 56 years:</u> <input type="checkbox"/> Functional or anatomic asplenia <input type="checkbox"/> Complement, properdin, factor D deficiency or primary antibody deficiency <input type="checkbox"/> Cochlear implant recipients (pre/post implant) <input type="checkbox"/> Acquired complement deficiency (e.g., receiving eculizumab) <input type="checkbox"/> HIV

Location to be picked up (please check):

- Gravenhurst Huntsville Orillia

VIM Order # (for office use only): _____

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

Location to be picked up (please check):

Gravenhurst Huntsville Orillia

VIM Order # (for office use only): _____

2022-06-23

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