

Referral Form: Immunization & TB Testing
For use by Health Care Providers

Name: _____

Provincial Health Number: _____

Previous names (if applicable): _____

Address: _____

DOB (yyyy-mm-dd): _____

Place client lived as a child (if applicable): _____

Phone: _____

Family doctor/nurse practitioner: _____

IMMUNIZATIONS REQUESTED
Refer to the [PEI Adult Immunization Schedule](#) or [PEI Childhood Immunization Schedule](#) for information on publicly funded vaccines.
 Request Public Health Nursing complete assessment for all necessary immunizations
OR indicate vaccine being requested below:

<input type="checkbox"/> Haemophilus Influenzae type B (Hib)	<input type="checkbox"/> Measles, Mumps, Rubella	<input type="checkbox"/> Tdap
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Meningococcal	<input type="checkbox"/> Varicella
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Mpox	<input type="checkbox"/> Other _____
<input type="checkbox"/> Human Papilloma Virus (HPV)	<input type="checkbox"/> Polio	
<input type="checkbox"/> Herpes Zoster (HZ)	<input type="checkbox"/> Pneumococcal	
	<input type="checkbox"/> Respiratory Syncytial Virus (RSV)	

IMMUNIZATION HISTORY

Has the client received **any** vaccines through your office/clinic previously? Please indicate below (use back of sheet if more space is needed):

Vaccine: _____ Date Given: _____

Vaccine: _____ Date Given: _____

 Not Applicable

RELEVANT CLINICAL INFORMATION
Relevant clinical information must be provided:

<input type="checkbox"/> Splenic disorders	<input type="checkbox"/> HIV
<input type="checkbox"/> Solid organ transplant	<input type="checkbox"/> Hematopoietic stem cell transplant
<input type="checkbox"/> Cochlear implant	<input type="checkbox"/> Immunocompromising therapy
<input type="checkbox"/> Other: _____	

Please indicate if this referral is time sensitive (e.g. surgery is booked, starting disease modifying agent) and specify time frame: _____

TB TESTING REQUESTED

<input type="checkbox"/> Diagnosis of Medical Condition	<input type="checkbox"/> Pre-Medication Initiation
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Please complete ALL details below and indicate the best way to reach you should we need to consult further on this request.

<input type="checkbox"/> Email _____
<input type="checkbox"/> Phone _____
<input type="checkbox"/> Fax _____

Worksite/Location: _____

Date of Request: _____

Providers Name (print): _____ **Signature:** _____
HCP Designation: _____

Please Fax Completed Form to Health PEI Public Health Nursing

Health PEI Public Health Nursing (PHN)	Fax	Phone
O'Leary PHN	902-859-0399	902-859-8720
Summerside PHN	902-888-8153	902-888-8160
Charlottetown PHN	902-368-4497	902-368-4530
Montague PHN	902-838-0803	902-838-0762
Souris PHN	902-687-7048	902-687-7049

Please note: Health PEI Public Health Nursing does not provide travel immunization. Travelers are encouraged to go to a travel clinic for comprehensive travel medicine advice including immunization.