ACT Government Health

Special Immunisation Clinic Referral Form

Referrals only accepted for children 6 weeks to ≤16 years of age

COMMUNICABLE DISEASE CONTROL USE ONLY

Appointment date: ____/____ /_____ Appointment time:

REFERRER TO COMPLETE

DETAILS OF PERSON

Name____ DOB: ____/____ /_____

Gender M/F/Other______________ (circle) Medicare card number: ______________________________

Address ____ State__________ Postcode__________

Parent/Guardian name: ____Mobile ____________________

Email address: ____

Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ Neither ☐

Not stated ☐ Weight of Child_______________

PAST MEDICAL HISTORY

Allergies: ____

Medical conditions? (please attach summary/any relevant documents if available): ___________________________

____

____

Routine medications: ____

REASON FOR REFERRAL

☐ previous serious adverse event following immunisation (will be confirmed by Public Health Physician or Public Health Registrar) Please provide a summary of reaction and to which vaccine :

____

____

____

☐ anaphylaxis to previous vaccine (or vaccine component);

☐ does not fit above criteria – please call Immunisation Public Health Nurse or Immunisation Coordinator on 6205 2300 to discuss

*Please note: egg allergy (including anaphylaxis) is not a contraindication to administering MMR or most influenza containing vaccines.

VACCINES REQUESTED

☐ Diphtheria, Tetanus, Pertussis ☐ *Haemophilus Influenzae* Type B ☐ Paediatric Hepatitis B

☐ Adult Hepatitis B ☐ Human Papillomavirus ☐ Influenza

☐ Measles, Mumps, Rubella ☐ Meningococcal C ☐ Poliomyelitis

☐ Pneumococcal ☐ Rotavirus ☐ Varicella

☐ Other (please specify)

REFERRER DETAILS:

Name: ____

Phone number: __________________________ Fax number: _______________________

Referrer type:

☐ General Practitioner ☐ Paediatrician ☐ Immunologist

☐ Oncologist ☐ AEFI meeting ☐ Other (please specify)

REFERRERS SIGNATURE

Signature:____ Date:____/_____/________

ACT Government Health

Special Immunisation Clinic Referral Form

Referrals only accepted for children 6 weeks to ≤16 years of age

PATIENTS MEDICAL TEAM

General Practitioner: ____ Phone: __________________

Address:____

Paediatrician/Specialist (if applicable): ______________________________ Phone: __________________

Child's usual immunisation provider: ____

PRIVACY STATEMENT

Please advise the parent/guardian that their information will be provided to Immunisation, Communicable Disease Control at Health Protection Service and Paediatric Day Stay Unit at Centenary Hospital for Women and Children.

Referrers Signature:______________________ Date advised: ____ /____ /_____

MEDICATIONS

If you wish the patient to have any medications pre or post vaccination please complete the request below:

Medication	Dose	Time	Route	Signature

ADDITIONAL INFORMATION

____
____
____
____
____
____
____
____

COMMUNICABLE DISEASE CONTROL USE ONLY

Referral accepted? Yes/No If no, why? ____ _________

Accepted by Signature:______________________________**Position:**______________________________________

Vaccinations recommended:

- ☐ **Diphtheria, Tetanus, Pertussis**
- ☐ ***Haemophilus Influenzae* Type B**
- ☐ **Paediatric Hepatitis B**
- ☐ **Adult Hepatitis B**
- ☐ **Human Papillomavirus**
- ☐ **Influenza**
- ☐ **Measles, Mumps, Rubella**
- ☐ **Meningococcal C**
- ☐ **Poliomyelitis**
- ☐ **Pneumococcal**
- ☐ **Rotavirus**
- ☐ **Varicella**
- ☐ **Other (please specify)** ____

Parents contacted for appointment date and time? Date: ____/____ /____

Attended SIC: ____/____/______ **Follow up phone call date:** ____/____/______

Correspondence completed: ____/____/______

Advice for further vaccinations:____

Email: immunisation@act.gov.au
Fax: 02-6205 1738
If faxing please also post a copy to: Immunisation Unit, Health Protection Service, Locked Bag 5005, WESTON, ACT, 2611

00000(0816)