ACT Government | ACT Health

Special Immunisation Clinic Referral Form

Referrals only accepted for National Immunisation Program vaccines 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_____ 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 _____ Gestational age:_____

PAST MEDICAL HISTORY

Allergies: [l] _____

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)

☐ Other– please call Immunisation Public Health Nurse or Immunisation Coordinator on 6205 2300 to discuss.

* Persons with egg allergy (including anaphylaxis) can safely receive MMR vaccine in any setting.

Persons with egg allergy can safely receive influenza vaccine in any setting. Persons with egg anaphylaxis should be vaccinated in a medical facility with staff experienced in recognising and treating anaphylaxis

VACCINES REQUESTED

☐ Diphtheria, Tetanus, Pertussis	☐ *Haemophilus Influenzae* Type B	☐ Paediatric Hepatitis B
☐ Adult Hepatitis B	☐ Human Papillomavirus	☐ Influenza
☐ Measles, Mumps, Rubella	☐ Meningococcal A,C,W,Y	☐ Poliomyelitis
☐ Pneumococcal	☐ Rotavirus	☐ Varicella

☐ Other (please specify)

REFERRER DETAILS:

Name: _____

Phone number: [b] _____ Fax number: [c] _____

Referrer type:

☐ General Practitioner	☐ Paediatrician	☐ Immunologist
☐ Oncologist	☐ AEFI meeting	☐ Other (please specify)

REFERRER'S SIGNATURE

Signature:_____ Date:____/_____/_____

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PATIENT'S 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? _____ _____

Signature: _____ **Name:** _____ **Position:** _____

Vaccinations recommended:

- ☐ **Diphtheria, Tetanus, Pertussis**
- ☐ ***Haemophilus Influenzae* Type B**
- ☐ **Paediatric Hepatitis B**
- ☐ **Adult Hepatitis B**
- ☐ **Human Papillomavirus**
- ☐ **Influenza**
- ☐ **Measles, Mumps, Rubella**
- ☐ **Meningococcal A,C,W,Y**
- ☐ **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 5124 9307

If faxing please also post a copy to:

Immunisation Unit, Health Protection Service,

Locked Bag 5005, WESTON, ACT, 2611