Patient Information

Prescription of vaccines and screening for patients with new diagnosis or new treatment

To:
Fax : **Date:**

Diagnosis : **New treatment :**

Expected start date:

Blood samples collected on (optional) :
(including CBC, varicella, MMR, HepB ; Results in DSQ)

Necessary Interventions

☐ **PPD (TCT)**
Date : Results :

☐ **Shingrix** for shingles – 1st dose before new treatment
Date dose #1 : Date dose #2 :

☐ Other vaccine(s) :

☐ Update of vaccines as per PIQ (see table).

Vaccine	Recommendation	Refused	Completed / Date
Engerix B 20mcg/ml	In 3 doses: Month 0,1,6 **Immunocompromised patients: Double the dose (40mcg/2ml)**	☐	☐
Twinrix 20mcg+720IU/mL	-In 3 doses: Month 0,1,6 -Rapid option: Day 0,7,21 & month 12	☐	☐
Diphteria / Tetanos	Booster at ≥ 50yrs	☐	☐
Hib	Recommended	☐	☐
Influenza (Flu)	Every year	☐	☐
Prevnar13 Pneumovax	Recommended ≥8 weeks after prevnar & q5 yrs	☐	☐
HPV (specify vaccine)	Men and wommen between 9 and 26 yrs; Women up to 45yrs	☐	☐
MMR*	If not immune (2 doses)	☐	☐
Varicella*	If not immune (2 doses)	☐	☐
Other :			

Nurse : _____

*If necessary to give a live vaccine, advise the physician beforehand

Comments :

☐ **Verbal consentement received from patient to be contacted and for service**

Prescribers signature : **Licence :**

Return completed form : ☐ **By Fax :**
☐ **By email :**