Vital Health Pharmacy #2
560 West Ave., Kelowna, BC V1Y 4Z4
Fax: 778-738-3196
Phone: 778-738-3195

Vaccination Referral

Patient Label
(Name)______________________________
(PHN)______________________________
(DOB)______________________________
(Phone)______________________________
(Address)______________________________
____
____

Today's date ________/_________/__________

Patient allergies:

____

Current Medication(s):

____

____

Patient Status / Vaccination History:

☐ Due for vaccination update per BCCDC guidelines, no change in medications planned
☐ Will be starting a biologic medication ___________________(drug) on ____________________(date) and requires update to vaccinations per BCCDC guidelines
☐ Titre results included in the referral
☐ Previous vaccination unknown
☐ Previous vaccination history known & other instructions :

____

____

Recommended vaccines:

Vaccine	Given by	Date
☐ Influenza (Public Health)...		
☐ Covid-19 (Public Health)		
☐ Measles, Mumps, Rubella (MMR, Public Health)........................		
☐ Tetanus, Diphtheria (Td, Public Health)		
☐ Tetanus, Diphtheria, Pertussis (Tdap, Public Health)		
☐ Hib (H. influenzae type B, Public)		
☐ Pneumococcal Conjugate (Prevnar 20, Public)		
☐ Shingles (Shingrix 2 doses, 2 months apart)		
☐ ________________________________		
☐ ________________________________		
☐ ________________________________		

______________________________________ ______________________________

Health Professional Name, Credentials (Please print) Health Professional Signature

RETURN FAX NUMBER FOR PROOF OF VACCINATION:____________________

SEND BY FAX TO VITAL HEALTH PHARMACY #2 : 778-247-2309