

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:

- 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 (Pevnar 20, Public)
- Shingles (Shingrix 2 doses, 2 months apart)
- _____
- _____
- _____

Given by	Date

 Health Professional Name, Credentials (Please print)

 Health Professional Signature

RETURN FAX NUMBER FOR PROOF OF VACCINATION: _____

SEND BY FAX TO VITAL HEALTH PHARMACY #2 : 778-738-3196