BC Centre for Disease Control
An agency of the Provincial Health Services Authority

Referral Form for Live Attenuated Influenza Vaccination

Date:	
	YYYY/MM/DD

LIVE ATTENUATED INFLUENZA VACCINATION OF PEDIATRIC ONCOLOGY CLIENTS, INCLUDING AUTOLOGOUS HSCT, WHO ARE AT LEAST 12 MONTHS POST TREATMENT REQUIRES PHYSICIAN OR NURSE PRACTITIONER APPROVAL (i.e., the primary care physician, medical specialist or nurse practitioner most familiar with the client's current medical status).

CLIENT INFORMATION

Name:			
	Last	*First*	
DOB:		PHN:	
	YYYY/MM/DD		

To be completed by public health nurse:

❑ Pediatric oncology treatment, including autologous HSCT (12 months after discontinuation of therapy).

Concern regarding current medical status:

Public Health Nurse Name:			
Phone #:		Fax #:	

To be completed by physician or nurse practitioner and sent to public health nurse.

I have verified on (*YYYY/MM/DD*) ___________________, this client has no medical contraindications to the receipt of live attenuated influenza vaccine. I understand that children under 9 years of age who have not previously received any seasonal influenza vaccine require 2 doses given 4 weeks apart.

Signature:		Clinic:	
Phone #:		Fax #:	