

Date:	
	YYYY/MM/DD

MMR VACCINATION OF IMMUNOCOMPROMISED CLIENTS REQUIRES PHYSICIAN OR NURSE PRACTITIONER APPROVAL: the primary care physician, medical specialist or nurse practitioner most familiar with the client's current medical status.

CLIENT INFORMATION

Name:		
	<i>Last</i>	<i>First</i>
DOB:		PHN:
	YYYY/MM/DD	

MMR vaccine is available for susceptible immunocompromised clients listed below.

Check the appropriate box for your client:

- HSCT recipient ≥2 years post-transplant (provided there is no GVHD, immunosuppression has been discontinued for at least 3 months, and the client is deemed immunocompetent by a transplant specialist).
- Pediatric oncology treatment, including autologous HSCT (12 months after discontinuation of therapy).
- Acute lymphocytic leukemia in remission for at least 12 months (total lymphocyte count must be $\geq 1.2 \times 10^9/L$), and client **not** receiving radiation therapy at the time of immunization. If client is still receiving maintenance chemotherapy, it should be withheld for at least 1 week before to 1 week after immunization.
- Chronic Kidney Disease/Dialysis
- Solid Organ Transplant Candidate: complete MMR at least 4 weeks prior to transplantation.
- Asplenia/Hyposplenia (congenital, surgical removal or functional)
- Adults who are no longer immunocompromised due to malignant disease **and** ≥3 months after completion of immunosuppressive treatment [≥6 months if treated with anti-B-cell antibodies (e.g., rituximab)], not including SOT or HSCT recipients.
- ≥1 month after completion of high dose (≥2 mg/kg or ≥20 mg daily) oral corticosteroid therapy ≥14 days duration.
- ≥3 months after completion of immunosuppressive therapy [≥6 months if treated with anti-B-cell antibodies (e.g., rituximab)].
- Isolated immunodeficiencies:
 - Humoral (Ig) deficiency diseases
 - Neutrophil deficiency diseases
 - Complement deficiency diseases
- Other (specify): _____
- HIV-infected client, by age group ^A

Immunologic category	<12 months		1-5 years		≥6 years	
	CD4+ T-lymphocyte counts ($\times 10^6/L$)	Percent (%) of total lymphocytes	CD4+ T-lymphocyte counts ($\times 10^6/L$)	Percent (%) of total lymphocytes	CD4+ T-lymphocyte counts ($\times 10^6/L$)	Percent (%) of total lymphocytes
1	≥1,500	≥34	≥1000	≥30	≥500	≥26
2	750-1,499	26-33	500-999	22-29	200-499	14-25

Individuals with specific health conditions should be immunized with MMR vaccine according to principles outlined in the [BC Communicable Disease Control Manual, Chapter 2: Immunization, Part 2 - Immunization of Special Populations](#).

^A [NACI](#) recommends that HIV infected individuals who are not severely immunosuppressed (i.e., immunological categories 1 and 2) may be immunized with 2 doses of MMR vaccine separated by 3 months.

PHYSICIAN OR NURSE PRACTITIONER APPROVAL IS REQUIRED FOR LIVE VACCINES: the primary care physician, medical specialist or nurse practitioner most familiar with the client's current medical status.

CLIENT INFORMATION

Name:					
	<i>Last</i>		<i>First</i>		
DOB:			PHN:		
	YYYY/MM/DD				

**To be completed by physician or nurse practitioner and sent to Public Health Nurse.
Must be renewed after 4 months.**

I have verified on (YYYY/MM/DD) _____, this client has no medical contraindications to the receipt of live attenuated MMR vaccine. I understand that individuals may require up to 2 doses given up to 3 months apart, and verify that this client's condition is sufficiently stable to permit receipt of 2 doses, during a period of 4 months from the date above.

Signature:		Clinic:	
Phone #:		Fax #:	

To be completed by Public Health Nurse and returned to physician or nurse practitioner.

Public Health Nurse Name:			
Phone #:		Fax #:	

MMR Vaccine (2 doses, if indicated):

Date:		Lot #:		Site:	
Date:		Lot #:		Site:	