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

Referral Form for Rotavirus Vaccination

	Date:	
		YYYY/MM/DD

ROTAVIRUS VACCINATION OF CLIENTS WITH A SUSPECTED OR KNOWN IMMUNOCOMPROMISING CONDITION (SEE BELOW) 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:

Suspected contraindication to receipt of rotavirus vaccine:

- ❑ Infant with a suspected or known immunocompromising condition or family history of congenital or hereditary immunodeficiency.

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 oral rotavirus vaccine. I understand that infants may require up to 3 doses in a series to be completed by 8 months of age.

Signature:		Clinic:	
Phone #:		Fax #:	