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

Referral Form for Varicella Vaccination

Date:	
	YYYY/MM/DD

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

Varicella vaccine is available for susceptible [A] 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 ≥1.2 x 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 varicella 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 [B]

Immunologic category	<12 months		1-5 years		≥6 years	
	CD4+ T-lymphocyte counts (x10^6/L)	Percent (%) of total lymphocytes	CD4+ T-lymphocyte counts (x10^6/L)	Percent (%) of total lymphocytes	CD4+ T-lymphocyte counts (x10^6/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 varicella vaccine according to principles outlined in the BC Communicable Disease Control Manual, Chapter 2: Immunization, Part 2 - Immunization of Special Populations.

[A] As of June 2018, a varicella susceptible person is one without a history of lab confirmed varicella or herpes zoster after 12 months of age and without a history of age appropriate varicella immunization. Individuals with a documented exemption in the immunization registry prior to this date due to previous disease will be considered immune. A self-reported history of varicella or physician diagnosed varicella is adequate only if disease occurred before 2004.

[B] 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 varicella vaccine separated by 3 months.

Referral Form for Varicella Vaccination

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:			
	Last	*First*	
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 varicella 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 #:	

If applicable: Varicella IgG test result:		Date of test:	
			YYYY/MM/DD

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

Public Health Nurse Name:			
Phone #:		Fax #:	

Varicella Vaccine (2 doses, if indicated):

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