Peterborough Public Health

Physician or Hospital Specialty Program

COVID-19 VACCINE PATIENT REFERRAL FORM

Important to Note:

- Referral form to be completed **ONLY** when vaccination administration is unable to be completed intra-organizationally by Physician or Specialty Program responsible for eligible patient care.
- To refer an eligible candidate for a 3rd, 4th, or 5th dose of the COVID-19 vaccine, this form must be **COMPLETED IN FULL**, signed, and shared with the patient.
- Upon completion, this form may be provided digitally in .pdf format or physically to eligible patients.
- *Patient **MUST** present the completed form when attending their vaccination appointment*.
- Please note - If a patient is to receive another dose and their health status has not changed from their previous dose, the previously completed referral form will be accepted at the vaccine clinic for a patients next dose.

Patient Full Name:	**Today's Date (MM/DD/YYYY):**
Patient Health Card Number:	

Based on the Ontario COVID-19 Booster Dose Guidance Document from the Ministry of Health, Ontario is offering a 3 dose primary series (general population receives 2 doses) to select vulnerable populations which may be required to provide sufficient protection based on a suboptimal or waning immune response to vaccines and increased risk of COVID-19 infection.

This population, as defined in the Ontario COVID-19 Booster Dose Guidance Document, is also eligible for additional booster doses, similar to the general population. However, the interval between doses is different and patients will therefore require a referral form to receive these doses.

A full COVID-19 Immunization Schedule can be found here.

Patient Eligibility:

Please identify the relevant sub-category below of patient eligibility for a 3rd, 4th or 5th dose of the COVID-19 vaccine:
(NOTE: The Patient must meet one or more of the criteria listed below to be eligible for a 3 dose primary series.)

- ☐ Individuals receiving dialysis (hemodialysis or peritoneal dialysis)
- ☐ Transplant Recipient (Including: solid organ transplant and hematopoietic stem cell transplant);
- ☐ Patient with Hematological Cancer(s) and on Active Treatment for Malignant Hematologic Disorders (Disorders including: Lymphoma, Myeloma, Leukemia) (Treatments including: Chemotherapy, Targeted Therapies, Immunotherapy);
- ☐ Recipient of an anti-CD20 Agent (Including: Rituximab, Ocrelizumab, Ofatumumab);
- ☐ Those undergoing active treatment for solid tumors;
- ☐ Those who are in receipt of chimeric antigen receptor (CAR)-T-cell;
- ☐ Those with moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome);
- ☐ Stage 3 or advanced untreated HIV infection and those with acquired immunodeficiency syndrome; and
- ☐ Those undergoing active treatment with the following categories of immunosuppressive therapies: anti-B cell therapies (monoclonal antibodies targeting CD19, CD20 and CD22), high-dose systemic corticosteroids, alkylating agents, antimetabolites, or tumor-necrosis factor (TNF) inhibitors and other biologic agents that are significantly immunosuppressive.
- ☐ Those on an immunosuppressant medication. A full list of medications can be found on the Ontario COVID-19 Booster Dose Guidance Document.

Regional Vaccination Locations and Instructions:

Please visit: https://covid-19.ontario.ca/vaccine-locations to find a pharmacy location near you.

Patient-Specific Treatment Considerations and Scheduling:

Condition-Specific Treatment Needs:
☐ No Treatment Considerations (May book as recommended after previous dose)
☐ Yes, Treatment must be Considered Specific Scheduling Requirements:

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COVID-19 Dose Vaccination Schedule & Type(s):
First Dose
Vaccine Type:
Date (MM/DD/YYYY):
Second Dose
Vaccine Type:
Date (MM/DD/YYYY):
Third Dose (this will only need to be filled out if a third dose has been administered)
Vaccine Type:
Date (MM/DD/YYYY):
Fourth Dose (this will only need to be filled out if a third dose has been administered)
Vaccine Type:
Date (MM/DD/YYYY):
Fifth Dose – IF ELIGIBLE (this will only need to be filled out if a third dose has been administered)
Vaccine Type:
Date (MM/DD/YYYY):

Health Care Provider: ___________________________ CSPO#: _______________ Signature: _______________________________

I have provided counselling regarding the risks, benefits, and timing of next dose of COVID-19 vaccine in accordance with provincial guidance.
By signing, I confirm the information above to be true and accurate to the best of my knowledge.

REVISED: May 13, 2022