

Varicella Immunization Referral Form (Ages 1+ years)

Immunization of immunocompromised adults and children with live attenuated varicella vaccine **requires approval** from the medical specialist, primary care physician or nurse practitioner most familiar with the client's current medical status.

Patient name: _____

DOB: yyyy/mm/dd Gender _____ HSN _____

Check the appropriate condition below:

☐ HIV infection¹ – only individuals who are not severely immunosuppressed as indicated according to criteria based on age for immunization:		☐ Isolated immune deficiency² ☐ Humoral (Ig) deficiency diseases ☐ Neutrophil deficiency diseases ☐ Complement deficiency diseases ☐ Transplant recipient ☐ Kidney ☐ Liver ☐ HSCT ☐ Other (specify) _____ ☐ Long-term immunosuppressive therapy³ ☐ Other condition (specify): _____ _____ ☐ Comments: _____
Age 1 through 5 years old	Age ≥ 6 years old	
CD4+ T-lymphocyte counts (x10 ⁶ /L) for ≥ 6 months: ≥ 500	CD4+ T-lymphocyte counts (x10 ⁶ /L) for ≥ 6 months: ≥ 200	
Total lymphocytes: ≥ 15%	Total lymphocytes: ≥ 15%	

Section A OR B must be completed by a physician or a nurse practitioner and sent to the Public Health Centre

Section A

1) I verify on yyyy/mm/d that this patient **currently** has a medical contraindication to receiving varicella vaccine and cannot be immunized.

Section B

1) If applicable: VZV IgG result: _____ Date of titre: yyyy/mm/dd

2) I verify on yyyy/mm/dd that this patient **has no medical contraindications** to receiving varicella vaccine.

3) I understand that this patient may require up to 2 doses given at least 3 months apart and verify that this client's condition is sufficiently stable to receive up to 2 doses within an 8-month period from when this referral has been received at Public Health.

Signature: _____ ☐ MD ☐ NP Clinic: _____

Phone #: _____ Fax #: _____ Email: _____

Section C to be completed by Public Health Nurse and faxed back to physician or nurse practitioner:

Dose 1 date given: yyyy/mm/dd Lot #: _____

Dose 2 date given: yyyy/mm/dd Lot #: _____

Public Health Nurse's name (print): _____

Phone #: _____ Fax: _____ Email: _____

¹ Varicella and MMR may be administered on same day. **MMRV vaccine contraindicated.**

² Min. 4-week intervals **are required** between all Varicella and MMR vaccine doses. **MMRV vaccine contraindicated.**

³ **Live vaccines are contraindicated during immunosuppressive therapy.** However, the patient's clinical status, net state of immune suppression (including immunosuppressive medications and presence of opportunistic infections), and an in-depth immunologic evaluation are important consideration when deciding about risk versus benefit for live virus immunization.