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: _____ **Phone #:** _____

DOB: _____yyyy/mm/dd_____ **Gender** _____ **HSN** _____

Check the appropriate condition below:

☐ **HIV infection**[1] **– only individuals who are not severely immunosuppressed** as indicated according to criteria based on age for immunization:

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%**

☐ **Isolated immune deficiency**[2]
- ☐ Humoral (Ig) deficiency diseases
- ☐ Neutrophil deficiency diseases
- ☐ Complement deficiency diseases

☐ **Transplant recipient** ☐ Kidney ☐ Liver ☐ HSCT ☐ Other (specify)_____

☐ **Long-term immunosuppressive therapy**[3]

☐ **Other condition** (specify): _____

_____

☐ **Comments:** _____

_____

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.