Request Form for High Risk Meningococcal Vaccine

Vaccine being requested:

Description	Supply (in doses)	Dose Requested
4CMenB (Bexsero®) 2 months to 17 years	1 x 0.5 ml	
Men-C-ACYW (Menactra®) 9 months to 55yrs	1 x 0.5 ml	
Men-C-ACYW (Menactra®) 56 years or older	1 x 0.5 ml	

Clients who meet one of the following criteria:

- ☐ Functional or anatomic asplenia
- ☐ Complement, properdin, factor D deficiency, or primary antibody deficiencies
- ☐ Cochlear implant recipients (pre/post implant)
- ☐ Individuals with acquired complement deficiency (e.g. receiving eculizumab)
- ☐ Individuals with HIV

Client File Number: _____

Date of Birth (yyyy/mm/dd): _____ Male: ☐ Female: ☐

Dose being requested: Dose 1: ☐ Dose 2: ☐ Dose 3: ☐ Booster dose: ☐

Date previous doses given (yyyy/mm/dd): Dose 1_____ Dose 2 _____

*Date of scheduled appointment (order will not be filled if the appointment date is not provided) (yyyy/mm/dd): _____

Name of HCP: _____ Date of Request (yyyy/mm/dd): _____

HCP address: _____

Please return by Fax (613-580-2783) or email (vaccine@ottawa.ca)

For Vaccine Room Use ONLY

Date order filled: _____

Vaccine: _____ Lot Number: _____

Filled by: _____

Revised September 2016