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Pharmaceutical Opinion – Vaccination Update

Patient Name: _____

Date: _____ **M☐** **F☐** **DOB:** _____

Dear Dr._____,

_____ received the _____ vaccine on _____.

Based on the following co-morbidities;

Cardiovascular Disease ☐ **Asthma/C.O.P.D ☐**

Respiratory Disease ☐ **Diabetes ☐**

Over age 65 ☐ **Other ☐ _____**

I am suggesting the following adult vaccine(s):

☐ Tdap (in office – funded by public health)

☐ Prevnar 13 (on prescription - only publically funded for immunocompromised patients over 50 years of age).

Dr. initial: _____

☐Pneumovax (in office – 65+ funded by public health). To be administered 8 weeks after Prevnar 13

Dr. initial: _____

☐ Shingrix (on prescription. Non-live vaccine. 2 doses required 2-6 months apart. Protected only after 2nd dose)

Dr. initial: _____

☐ Other_____ Dosing (if applicable) _____ Dr. initial: _____

Notes: _____

_____

_____

_____

☐ I agree with the vaccine recommendation(s) listed that are not publicly funded for this patient (please initial by listed vaccine).

☐ I prefer not to prescribe at this time and will follow-up with patient.

Thank you for taking the time to complete this form. Please sign and date so that we can accept this as a valid prescription.

Thank you,

Pharmacist