



Patient Name: _____

Date of Birth: _____

Immunization Prescription

Date: _____

Drug allergies: _____

No known drug allergy

<input type="checkbox"/> Pneumococcal 13-valent conjugate vaccine (PREVNAR®-13) Sig: Inject 0.5 mL IM x 1 dose Qty: **0.5 (Zero Point Five) mL** Refill: **0 (Zero)**	<input type="checkbox"/> Pneumococcal polyvalent vaccine (PNEUMOVAX®-23) Sig: Inject 0.5 mL IM x 1 dose Administer > 8 weeks after receiving Prevnar 13 Qty: **0.5 (Zero Point Five) mL** Refill: **0 (Zero)**
<input type="checkbox"/> Herpes zoster non-live recombinant vaccine (SHINGRIX®) Sig: Inject 0.5 mL IM x 2 doses Administer first dose at month 0 and second dose at 2-6 months Qty: **0.5 (Zero Point Five) mL** Refill: **1 (One)**	<input type="checkbox"/> Human papillomavirus 9-valent recombinant vaccine (GARDASIL®-9) Sig: Inject 0.5 mL IM x 3 doses Administer at months 0, 2 and 6 Qty: **0.5 (Zero Point Five) mL** Refill: **2 (Two)**
<input type="checkbox"/> Hepatitis B recombinant vaccine (ENGERIX®-B) 20 mcg/mL Sig: Inject 2 mL (40 mcg total) IM x 4 doses Administer at months 0, 1, 2 and 6 <i>Note to pharmacy: Give 2 x 20 mcg (1 mL) vials for 40 mcg (2 mL) dose</i> Qty: **2 (Two) mL** Refill: **3 (Three)**	<input type="checkbox"/> Haemophilus influenza type b conjugate vaccine – CHOOSE ONE (<input type="checkbox"/> Act-HIB® or <input type="checkbox"/> HIBERIX®) Sig: Inject 0.5 mL IM x 1 dose Qty: **0.5 (Zero Point Five) mL** Refill: **0 (Zero)**
OR <input type="checkbox"/> Hepatitis B recombinant vaccine (RECOMBIVAX®-HB) 40 mcg/mL Sig: Inject 1 mL (40 mcg total) IM x 3 doses Administer at months 0, 1 and 6 Qty: **1 (One) mL** Refill: **2 (Two)**	<input type="checkbox"/> Meningococcal multicomponent serogroup B vaccine (BEXSERO®) Sig: Inject 0.5 mL IM x 2 doses Administer at weeks 0 and 4 Qty: **0.5 (Zero Point Five) mL** Refill: **1 (One)**
<input type="checkbox"/> Meningococcal A,C,Y and W-135 quadrivalent conjugate vaccine – CHOOSE ONE (<input type="checkbox"/> MENACTRA® or <input type="checkbox"/> MENVEO® or <input type="checkbox"/> NIMENRIX®) Sig: Inject 0.5 mL into the muscle x 2 doses Administer at weeks 0 and 8 Qty: **0.5 (Zero Point Five) mL** Refill: **1 (One)**	

Prescriber Name (PRINT): _____ CPSO Number: _____

Prescriber Signature: _____ GN Clinic Tel: _____
(clinic telephone number)

Rx PROVIDED to Patient Rx FAXED to Pharmacy: _____

***** If vaccine is administered in the pharmacy, please notify the GN Clinic as each vaccine is administered**

(Fax: _____)***
(clinic fax number)

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