Ontario Renal Network

Patient Name:

Date of Birth:

Immunization Prescription

Date: _____

Drug allergies: _____ ☐ No known drug allergy

☐ **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)**	☐ **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)**
☐ **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)**	☐ **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)**
☐ **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** ***Note to pharmacy: Give 2 x 20 mcg (1 mL) vials for 40 mcg (2 mL) dose*** Qty: **2 (Two) mL** Refill: **3 (Three)** **OR** ☐ **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)**	☐ **Haemophilus influenza type b conjugate vaccine – CHOOSE ONE** **(☐ Act-HIB® or ☐ HIBERIX®)** Sig: Inject 0.5 mL IM **x 1 dose** Qty:**0.5 (Zero Point Five) mL** Refill: **0 (Zero)**
☐ **Meningococcal A,C,Y and W-135 quadrivalent conjugate vaccine – CHOOSE ONE** **(□ MENACTRA® or □ MENVEO® or □ 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)**	☐ **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)**

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)

Version 1 – September 2019

Ontario