P.O. Box 897
Hamilton, Ontario,
Canada L8N 3P6
www.hamilton.ca

Public Health Services
Epidemiology, Wellness & Communicable Disease Control Division
110 King St W, 4th Floor, Hamilton, ON L8P 4S6
Phone:289-440-1849 Fax: 844-444-0295

Immunocompromised Imvamune® Vaccine Referral Form

Moderately to severely immunocompromised individuals who are currently eligible for pre-exposure vaccination are to receive two doses of Imvamune® vaccine, at least 28 days apart. Please complete, sign and fax this referral form to 844-444-0295. Hamilton PHS will directly call your patient to book a date and time.

Last Name	**First Name**	**Health Card No.**
Date of Birth (mm/dd/yyyy)	**Name of Referring Physician** (please print)	
Client phone (preferred)	**Email address** (alternate - only if phone is not available)	

Reason for Imvamune® vaccine*: (this section must be completed)

- ☐ Receiving active treatment (e.g., chemotherapy, targeted therapies, immunotherapy) for solid tumor or hematologic malignancies (Active treatment includes patients who have completed treatment within the last 3 months).
- ☐ Recipient of solid-organ transplant and taking immunosuppressive therapy
- ☐ Recipient of chimeric antigen receptor (CAR)-T-cell therapy or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy)
- ☐ Moderate to severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)
- ☐ HIV with current CD4 count ≤ 200/mm3 or prior CD4 Fraction ≤ 15% or detectable viral load (i.e., not suppressed)
- ☐ Receiving dialysis (hemodialysis or peritoneal dialysis)
- ☐ Receiving active treatment with the following categories of immunosuppressive therapies: anti-B cell therapies (monoclonal antibodies targeting CD19, CD20 and CD22), high-dose systemic corticosteroids (refer to the Canadian Immunization Guide for suggested definition of high dose steroids), alkylating agents, antimetabolites, or tumor-necrosis factor (TNF) inhibitors and other biologic agents that are significantly immunosuppressive (Active treatment for patients receiving B-cell depleting therapy includes patients who have completed treatment within the last 12 months)

Patient Counselling and Physician Signature (this section must be completed)

- ☐ I have provided counselling regarding the risks, benefits, and timing of the additional Imvamune® vaccine dose.

Physician Signature: _____

***Health conditions other than those listed, will not be accepted as a reason to receive Imvamune®.

Aug 22/24