



Second Dose Imvamune® Vaccine Referral Form

Moderately to severely immunocompromised individuals are eligible to receive two doses of Imvamune® vaccine, at least 28 days apart. Please complete, sign and fax this referral form to 905-546-4078. 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 second dose of Imvamune® vaccine*: (this section must be completed)		
<input type="checkbox"/> 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).		
<input type="checkbox"/> Recipient of solid-organ transplant and taking immunosuppressive therapy		
<input type="checkbox"/> Recipient of chimeric antigen receptor (CAR)-T-cell therapy or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy)		
<input type="checkbox"/> Moderate to severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)		
<input type="checkbox"/> HIV with current CD4 count $\leq 200/\text{mm}^3$ or prior CD4 Fraction $\leq 15\%$ or detectable viral load (i.e., not suppressed)		
<input type="checkbox"/> Receiving dialysis (hemodialysis or peritoneal dialysis)		
<input type="checkbox"/> 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)		
<input type="checkbox"/> 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 a 2nd dose of Imvamune®.