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Public Health Services
Epidemiology, Wellness & Communicable Disease Control Division
110 King St W, 2nd Floor, Hamilton, ON L8P 4S6
Phone: 905-546-2063 Fax: 905-546-4078

Hamilton

Physician Attestation Form for Higher-Risk Contact of Individual Eligible for Monkeypox PrEP

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 for vaccination.

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)	

☐ Pregnant

☐ 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)

Physician Attestation and Signature (this section must be completed)

☐ I attest that my patient, named above, may be at higher risk for severe illness from a monkeypox infection given they are moderately to severely immunocompromised and/or pregnant (as indicated above) and are a household member or a sexual contact of an individual who is eligible for monkeypox PrEP. I have provided the necessary counselling regarding the risks, benefits, and timing of the 2-dose primary Imvamune® series.

Physician Signature: _____