

**PNEUMOCOCCAL VACCINATION ASSESSMENT (No Response Required)**

Store:	
Address:	
Phone:	Fax:

Patient Information			
First Name:		Last Name:	
DOB:	AGE:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> NOS	Pregnant: <input type="checkbox"/> Y <input type="checkbox"/> N
PHN:	Phone:	Lactating: <input type="checkbox"/> Y <input type="checkbox"/> N	

Prescriber Notification			
Dear Dr.:		Date of notification:	
Method:	Fax:	Phone:	Other:
The above patient was provided with a Pneumococcal Assessment using the ACIP guidelines on: DATE:			

Patient Data	YES	NO
Is the patient ≥ 65 Yrs?	<input type="checkbox"/>	<input type="checkbox"/>
Is patient a resident of a nursing home or chronic facility?	<input type="checkbox"/>	<input type="checkbox"/>
Is patient age 2-64 with any of the following risks?		
Chronic cardiac disease	<input type="checkbox"/>	<input type="checkbox"/>
Chronic liver disease	<input type="checkbox"/>	<input type="checkbox"/>
CSF Leak	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Functional or anatomic asplenia	<input type="checkbox"/>	<input type="checkbox"/>
Immunocompromised/supressed	<input type="checkbox"/>	<input type="checkbox"/>
Renal failure	<input type="checkbox"/>	<input type="checkbox"/>
Active smoker	<input type="checkbox"/>	<input type="checkbox"/>
If the answer is NO to ALL of the ABOVE: STOP assessment DO NOT give the vaccine		
Do you have hypersensitivity to any vaccine component (incl: diphtheria toxoid)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have moderate to severe acute illness?	<input type="checkbox"/>	<input type="checkbox"/>
1 <sup>st</sup> trimester pregnancy - safety no evaluated		
If the answer is YES to ANY of the ABOVE: STOP assessment DO NOT give the vaccine		
Has the patient previously received the pneumococcal vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Prevnar (PC13)	Date:	
Pneumovax 23 (PPSV23)	Date:	
Both	Date:	

PHARMACY USE ONLY			
<b>Assessment</b>			
<input type="checkbox"/> Pneumococcal vaccine indicated			
<input type="checkbox"/> Pneumococcal vaccine NOT indicated			
<b>Action</b>			
<input type="checkbox"/>	Recommend PPSV 23	<input type="checkbox"/>	Recommend PV13 by PPSV23 @ interval
<input type="checkbox"/>	Recommend PCV13	<input type="checkbox"/>	Recommend PPSV23 followed by PCV13 @interval
<input type="checkbox"/>	Prescribed PPSV23	<input type="checkbox"/>	Prescribed PCV13 followed by PPSV23 @interval
<input type="checkbox"/>	Prescribed PCV13	<input type="checkbox"/>	Prescribed PPSV23 followed by PCV13 @interval
<input type="checkbox"/>	Administered PPSV23	<input type="checkbox"/>	Administered PCV13
Intramuscular site: <input type="checkbox"/> Left arm <input type="checkbox"/> Right arm			
Response:			
Vaccine selection (PPSV23/PCV13) Lot & Expiry:			
YYYY-MM-DD			
Plan/Monitoring:			
Pharmacist will call patient on: _____			
Patient counselled and advised to contact pharmacist if adverse reactions are noted			
OTHER:			

Pharmacist	License No.	Date
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