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PNEUMOCOCCAL VACCINATION ASSESSMENT (No Response Required)

Store:	
Address:	
Phone:	Fax:

Patient Information			
First Name:		Last Name:	
DOB:	AGE:	Gender: ☐M ☐F ☐ NOS	Pregnant: ☐ Y ☐N
PHN:	Phone:		Lactating: ☐ Y ☐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?	☐	☐
Is patient a resident of a nursing home or chronic facility?	☐	☐
Is patient age 2-64 with any of the following risks?		
Chronic cardiac disease	☐	☐
Chronic liver disease	☐	☐
CSF Leak	☐	☐
Diabetes	☐	☐
Functional or anatomic asplenia	☐	☐
Immunocompromised/supressed	☐	☐
Renal failure	☐	☐
Active smoker	☐	☐
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)?	☐	☐
Do you have moderate to severe acute illness?	☐	☐
1st 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?	☐	☐
Prevnar (PC13)	Date:	
Pneumovax 23 (PPSV23)	Date:	
Both	Date:	

Pharmacist License No. Date

PHARMACY USE ONLY

Assessment

☐ Pneumococcal vaccine indicated
☐ Pneumococcal vaccine NOT indicated

Action

☐	Recommend PPSV 23	☐	Recommend PV13 by PPSV23 @ interval
☐	Recommend PCV13	☐	Recommend PPSV23 followed by PCV13 @interval
☐	Prescribed PPSV23	☐	Prescribed PCV13 followed by PPSV23 @interval
☐	Prescribed PCV13	☐	Prescribed PPSV23 followed by PCV13 @interval
☐	Administered PPSV23	☐	Administered PCV13

Intramuscular site: ☐ Left arm ☐ 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: