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# SHINGLES (HERPES ZOSTER) 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: | Weight: | Lactating: ☐ Y ☐N |

| Prescriber Notification | | | |
|---|---|---|---|
| Dear Dr. | | Date of notification: | |
| Method: | Fax: | Phone: | Other: |
| The above patient was provided with a Shingles Prevention Assessment using NACI guidelines on: DATE: | | | |

| Patient Data | YES | NO |
|---|---|---|
| Is the patient <50 yrs old? | ☐ | ☐ |
| Do you currently have an active case of shingles? | ☐ | ☐ |
| Have you had shingles within the last year? | ☐ | ☐ |
| Have you received the Zostavax II shingles vaccine within the last year? | ☐ | ☐ |
| **Zostavax II Questions if Shingrix is unavailable:** | | |
| Are you pregnant, planning, or breastfeeding? | ☐ | ☐ |
| Do you have active untreated TB, lymphoma, leukemia, HIV/Aids, cellular immune deficiencies, any malignancies, stem cell or organ transplant? | ☐ | ☐ |
| Do you take methotrexate >0.4mg/kg/week? | ☐ | ☐ |
| Do you take prednisone >20mg/kg/day? | ☐ | ☐ |
| Do you take 6-mercaptopurine > 1.5 mg/kg/day? | ☐ | ☐ |
| Are you undergoing radiation or chemotherapy? | ☐ | ☐ |
| Are you allergic to neomycin or gelatin? | ☐ | ☐ |
| Have you received a live vaccine in the last 4 weeks? (30 days for Yellow Fever) | ☐ | ☐ |
| Do you take biologics (i.e. Remicaide, Humira, Enbrel, Orencia, Simponi, Rituxan, Cimzia)<br>• If yes, refer to immunologist | ☐ | ☐ |
| Have you had shingles in/around your eye, nose, or forehead?<br>• If yes, refer to ophthalmologist | ☐ | ☐ |
| Are you currently taking antiviral medication?<br>• Must be off 24 hours prior and 14 days after singles vaccination | ☐ | ☐ |

Pharmacist License No. Date

## PHARMACY USE ONLY

### Assessment

☐ Shingles vaccination indicated (NACI guidelines)
☐ Referral to specialist
☐Shingles vaccination not indicated

### Action

| | | | |
|---|---|---|---|
| ☐ | Recommend Shingrix Please provide Rx | ☐ | Recommend Zostavax II Please provide Rx |
| ☐ | Prescribed Shingrix 0.5 mL IM X 2 doses (0, 2-6 mos) Prescribing assessment form completed | ☐ | Prescribed Zostavax II 0.65 mL SC X 1 dose Prescribing assessment form completed |
| ☐ | Administered Shingrix Medication/vaccine consent form completed | ☐ | Administered Zostavax II Live vaccine consent form completed |

Injection Route: ☐ IM ☐ SC
Injection Site site: ☐ Left arm ☐ Right arm
Response:

Vaccine Lot & Expiry:
YYYY-MM-DD
Diluent Lot & Expiry:
YYYY-MM-DD

### Plan/Monitoring:

☐ Pharmacist will call patient on:_____
☐ Patient counselled and advised to contact pharmacist if adverse reactions are noted
☐ Shingrix – Call back entered to remind patient for second dose on: _____