

SHINGLES (HERPES ZOSTER) 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:	Weight:	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 Shingles Prevention Assessment using NACI guidelines on: DATE:			

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

PHARMACY USE ONLY			
Assessment			
<input type="checkbox"/> Shingles vaccination indicated (NACI guidelines)			
<input type="checkbox"/> Referral to specialist			
<input type="checkbox"/> Shingles vaccination not indicated			
Action			
<input type="checkbox"/>	Recommend Shingrix Please provide Rx	<input type="checkbox"/>	Recommend Zostavax II Please provide Rx
<input type="checkbox"/>	Prescribed Shingrix 0.5 mL IM X 2 doses (0, 2-6 mos) Prescribing assessment form completed	<input type="checkbox"/>	Prescribed Zostavax II 0.65 mL SC X 1 dose Prescribing assessment form completed
<input type="checkbox"/>	Administered Shingrix Medication/vaccine consent form completed	<input type="checkbox"/>	Administered Zostavax II Live vaccine consent form completed
Injection Route: <input type="checkbox"/> IM <input type="checkbox"/> SC			
Injection Site site: <input type="checkbox"/> Left arm <input type="checkbox"/> Right arm			
Response:			
Vaccine Lot & Expiry: YYYY-MM-DD			
Diluent Lot & Expiry: YYYY-MM-DD			
Plan/Monitoring:			
<input type="checkbox"/> Pharmacist will call patient on: _____			
<input type="checkbox"/> Patient counselled and advised to contact pharmacist if adverse reactions are noted			
<input type="checkbox"/> Shingrix - Call back entered to remind patient for second dose on: _____			
Pharmacist	License No.	Date	

The documents accompanying this communication contain confidential information that may be legally privileged and protected by Federal and Provincial Law. This information is intended for use only by the entity or individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner. If you are in possession of this protected health information, and are not the intended recipient, you are hereby notified that any improper disclosure, copying, or distribution of the contents of this information is strictly prohibited. Please notify the sender immediately and arrange for its destruction or return.