COVID-19 VACCINE THIRD DOSE

PHYSICIAN OR HOSPITAL SPECIALTY PROGRAM: PATIENT REFERRAL FORM:

IMPORTANT TO NOTE:

- Referral form to be completed ONLY when vaccination administration is unable to be completed by Physician or Speciality Program responsible for eligible patient care
- To refer an eligible candidate for a 3rd dose of the COVID-19 vaccine, this form MUST be completed in FULL
- Client MUST present the completed form when attending their vaccine appointment

Patient Name: _____ Date: ____/___/_____

Patient Health Card Number: _____

Based on the recommendation of the Chief Medical Officer of Health and health experts, Ontario is offering third doses of the COVID-19 vaccine to select vulnerable populations which may be required to provide sufficient protection based on a suboptimal or waning immune response to vaccines and increased risk of COVID-19 infection.

PATIENT ELIGIBILITY

The patient must meet one or more of the criteria listed below. Any other patients with other health conditions/criteria will not be accepted for third doses at this time. Please identify the relevant sub-category below of patient eligibility for a 3rd dose of the COVID-19 vaccine:

- ☐ Transplant Recipient (including solid organ transplant and hematopoietic stem cell transplant)
- ☐ Patient with Hematological Cancer(s) and on Active Treatment for Malignant Hematologic Disorders
  - Disorders including: Lymphoma, Myeloma, Leukemia
  - Treatments including: Chemotherapy, Targeted Therapies, Immunotherapy
- ☐ Recipient of an anti-CD20 Agent (including Rituximab, Ocrelizumab, Ofatumumab)

PATIENT SPECIFIC TREATMENT CONSIDERATIONS AND SCHEDULING

Please note that third dose vaccinations can be administered no earlier than 8 weeks (or 56 days) after the second dose.

Condition Specific Treatment Needs:

- ☐ No treatment considerations (may book 8 weeks after the second dose)
- ☐ Treatment must be considered
  - Specific scheduling requirements: _____

First/Second Dose Schedule and Types:

First Dose Vaccine Type: _____ Date: ____/____/_____

Second Dose Vaccine Type: _____ Date: ____/____/_____

Physician Name: _____ CSPO#: _____

Signature: _____

I have provided counselling regarding the risks, benefits, and timing of a 3rd dose of COVID-19 vaccine in accordance with provincial guidance. By signing, I confirm the information above to be true and accurate to the best of my knowledge.