

Last Name

First Name

Salutation

Changed

Save

Cancel

Address 1

Address 2

City

Prov

AB

Postal

Country

Canada

Email

+

Send

Quick Code

Phone Numbers (0)

F2

Ins

Del

Description	Phone

Family Doctor

F2

Clear

Birthdate

Age

Gender

Male

Female

Language

Height

+

Weight

+

PHN

Load

Delete

Comments (0)

F2

Ins

Del

Topic	Comment
Program:	
Student ID:	

Plans (0)

F2

SubPlan Code	Group ID	Client ID	Expiry

Name: _____			DOB: _____
Last Name (Please print)	First Name	Middle Initial	DD / MMM / YYYY
Home or Cell number: (_____) _____ - _____		Student ID: _____	
School: _____		Program: _____	Start Date: _____

Tetanus, Diphtheria & Pertussis	Polio	Measles, Mumps & Rubella	Varicella
Dates of primary series: #1 _____ #2 _____ #3 _____ Booster: Td / dTap: _____ (circle one) (date)	<input type="checkbox"/> Not required for this program: Date: _____ Dates of primary polio series: #1 _____ #2 _____ #3 _____ Booster: _____ (date)	MMR dates: #1 _____ #2 _____ Measles Date: _____ Mumps Date: _____ Rubella Date: _____	<input type="checkbox"/> Had disease Immunization date(s): _____ _____ <input type="checkbox"/> Positive serology on: Date: _____ <input type="checkbox"/> Sent for serology: Date: _____ <i>(Results will be mailed to student)</i>

Hepatitis B	Influenza
<input type="checkbox"/> Not required for this program: Date: _____ Dates of primary hep B series: #1 _____ #2 _____ #3 _____ Booster(s), if necessary: Date: _____ Date: _____ Date: _____	<input type="checkbox"/> Hep B vaccine not recommended for student <input type="checkbox"/> Positive serology on: Date: _____ <input type="checkbox"/> Sent for serology: Date: _____ <i>(Results will be mailed to student)</i> <input type="checkbox"/> Sent for serology: Date: _____ <i>(Results will be mailed to student)</i>
Immunized: _____ (date)	
Declined: _____ (date)	

TB / Mantoux Skin Test	
<input type="checkbox"/> Not required for this program: _____ (date)	<input type="checkbox"/> Previous positive - Sent for chest x-ray: _____ <i>(Results will be mailed to student)</i> (date)
TB Testing: 1 st test _____ Read: _____ Result: _____ mm (date) (date) 2 nd test _____ Read: _____ Result: _____ mm (if required) (date) (date)	Follow-up: Sent for chest x-ray: _____ Date: _____ <i>(Results will be mailed to student)</i>

Please note: Your school or agency will NOT receive a copy of any mailed results.

Record of Immunization

Name: _____ Student ID: _____
Last Name First Name

Health Care Professional Verification

This verifies the above individual has completed the **first** dose of recommended immunizations and a TB skin test, if applicable.

Health Unit Stamp

 RN Signature

 Date

This verifies the above individual has completed **all** recommended immunizations (including a TB skin test, if applicable), and has been sent for post Hepatitis B series serology, if needed.

Health Unit Stamp

 RN Signature

 Date

School/Agency Verifications

 Name/Signature

 Date

School/Agency Stamp

 Name/Signature

 Date

Patient	PHN / Healthcare Number		Expiry: _____		Alternate Identifier	
	Legal Last Name		Legal First Name		Middle Name	Date of Birth (dd-Mon-yyyy)
	Preferred Name		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X (Non-Binary/Prefer not to Disclose)			Phone
	Address		City / Town		Province	Postal Code
Provider(s)	Authorizing Provider Name (Last, First, Middle)		Address		Phone	
	Address		Phone		Clinic / Building Name	
	CC Provider ID	CC Submitter ID	Legacy ID			
	Clinic / Building Name		Clinic / Building Name		Clinic / Building Name	
Collection		Date (dd-Mon-yyyy)		Time (24h)	Location	
<input type="checkbox"/> Routine <input type="checkbox"/> Stat		Requisition Date		*F Denotes a fasting test *I Special instructions, see website		Hours Fasting _____ <input type="checkbox"/> Third Party Bill? Client _____
Hematology / Coagulation		Endocrinology		Clinical Information		
<input type="checkbox"/> CBC and Differential <input type="checkbox"/> CBC no Differential <input type="checkbox"/> D-dimer <input type="checkbox"/> Fibrinogen <input type="checkbox"/> INR <input type="checkbox"/> Reticulocyte Count		Cortisol: <input type="checkbox"/> Random <input type="checkbox"/> AM (0700-1000) <input type="checkbox"/> PM (1500-1800) <input type="checkbox"/> Estradiol <input type="checkbox"/> Follicle Stimulating Hormone (FSH) <input type="checkbox"/> Luteinizing Hormone (LH) <input type="checkbox"/> Parathyroid Hormone (PTH) <input type="checkbox"/> Progesterone <input type="checkbox"/> Prolactin <input type="checkbox"/> Testosterone, Total <input type="checkbox"/> Thyroid Stimulating Hormone (TSH) <input type="checkbox"/> Thyroid Stimulating Hormone (TSH), Progressive		Drug Levels / Monitoring <input type="checkbox"/> Ethanol Level, Blood Therapeutic Drug Monitoring: Dose Route <input type="checkbox"/> Oral <input type="checkbox"/> IV <input type="checkbox"/> Other Dose Regimen _____ How Long on Current Regimen? _____ Date of Last Dose or IV Complete _____ Time of Last Dose or IV Complete _____ Date of Next Dose or IV Start _____ Time of Next Dose or IV Start _____ <input type="checkbox"/> Carbamazepine <input type="checkbox"/> Phenytoin, Total <input type="checkbox"/> Cyclosporine Pre Dose <input type="checkbox"/> Sirolimus <input type="checkbox"/> Cyclosporine 2h Post <input type="checkbox"/> Tacrolimus <input type="checkbox"/> Digoxin <input type="checkbox"/> Theophylline <input type="checkbox"/> Lithium <input type="checkbox"/> Valproate <input type="checkbox"/> Phenobarbital <input type="checkbox"/> Other _____		
General Chemistry		Immunology / Serology		Antibiotics:		
<input type="checkbox"/> Albumin <input type="checkbox"/> Alkaline Phosphatase (ALP) <input type="checkbox"/> Alanine Aminotransferase (ALT) Bilirubin: <input type="checkbox"/> Total <input type="checkbox"/> Total and Conjugated <input type="checkbox"/> Calcium <input type="checkbox"/> C-Reactive Protein (CRP) <input type="checkbox"/> Creatine Kinase (CK) <input type="checkbox"/> Creatinine (eGFR) Electrolytes: <input type="checkbox"/> Sodium <input type="checkbox"/> Potassium <input type="checkbox"/> Ferritin <input type="checkbox"/> Gamma Glutamyl Transferase (GGT) <input type="checkbox"/> Glucose Fasting *F *I <input type="checkbox"/> Glucose Random <input type="checkbox"/> Hemoglobin A1c <input type="checkbox"/> HCG, Serum (Quantitative) Immunoglobulins: <input type="checkbox"/> A (IgA) <input type="checkbox"/> G (IgG) <input type="checkbox"/> M (IgM) <input type="checkbox"/> Lipase <input type="checkbox"/> Magnesium <input type="checkbox"/> Phosphate <input type="checkbox"/> Prostate Specific Antigen (PSA) <input type="checkbox"/> Protein Electrophoresis-Serum <input type="checkbox"/> Total Protein <input type="checkbox"/> Urate		<input type="checkbox"/> Epstein - Barr Virus Serology - IgM <input type="checkbox"/> Hepatitis A Virus Acute Serology - IgM <input type="checkbox"/> Hepatitis A Virus Immunity Serology - IgG <input type="checkbox"/> Hepatitis B Surface Antigen <input type="checkbox"/> Hepatitis B Surface Antibody <input type="checkbox"/> Hepatitis C Virus Serology <input type="checkbox"/> HIV 1 and 2 Serology (Antigen and Antibody) <input type="checkbox"/> Mononucleosis Screen <input type="checkbox"/> Rheumatoid Factor <input type="checkbox"/> Rubella Immunity Serology - IgG <input type="checkbox"/> Syphilis		Gentamicin <input type="checkbox"/> Pre <input type="checkbox"/> Post <input type="checkbox"/> Interval <input type="checkbox"/> Other Tobramycin <input type="checkbox"/> Pre <input type="checkbox"/> Post <input type="checkbox"/> Interval <input type="checkbox"/> Other Vancomycin <input type="checkbox"/> Pre <input type="checkbox"/> Other		
<input type="checkbox"/> Lipid Panel <input type="checkbox"/> Cholesterol <input type="checkbox"/> Triglycerides <input type="checkbox"/> Cardiovascular Disease Risk Assessment (includes Lipid Panel) Required History: Systolic Blood Pressure (mmHg) _____ Tobacco Use <input type="checkbox"/> Yes <input type="checkbox"/> No Treated for High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetic <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Atherosclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No First Degree Relative with CVD (M<55Y / F<65Y) <input type="checkbox"/> Yes <input type="checkbox"/> No		Cardiology		Urine Drug Testing Panels		
Glucose Tolerance Tests		Transfusion Medicine		Reason for Request _____		
<input type="checkbox"/> Glucose, Gestational Diabetes Screen (GDS) <input type="checkbox"/> Glucose Tolerance, Gestational, 2h *F *I <input type="checkbox"/> Glucose Tolerance, 2h *F *I		<input type="checkbox"/> Direct Antiglobulin Test (DAT) <input type="checkbox"/> RHIG Eligibility, Prenatal Type & Screen - separate process required, contact lab Prenatal Type & Screen - use CBS Perinatal Requisition		<input type="checkbox"/> Opioid Dependency Panel What is the Treatment Regimen? <input type="checkbox"/> Buprenorphine <input type="checkbox"/> Methadone <input type="checkbox"/> Morphine <input type="checkbox"/> Hydromorphone <input type="checkbox"/> Other _____		
Miscellaneous		Sterile Body Fluid		OR		
<input type="checkbox"/> FIT Colorectal Cancer Screening (Age 50-74) *I <input type="checkbox"/> H. pylori *I <input type="checkbox"/> Hemoglobinopathy Investigation		<input type="checkbox"/> Fluid Type _____ Source _____ Test(s) _____ Urine <input type="checkbox"/> Urinalysis Albumin (Creatinine Ratio) <input type="checkbox"/> Random <input type="checkbox"/> 24h Creatinine <input type="checkbox"/> Random <input type="checkbox"/> 24h Cortisol <input type="checkbox"/> Random <input type="checkbox"/> 24h Protein Electrophoresis <input type="checkbox"/> Random <input type="checkbox"/> 24h Total Protein (Creatinine Ratio) <input type="checkbox"/> Random <input type="checkbox"/> 24h <input type="checkbox"/> Creatinine Clearance 24h Ht _____ cm Wt _____ kg 24h Urine *I Total Volume _____ Start Date _____ Start Time _____ End Date _____ End Time _____		<input type="checkbox"/> General Toxicology Panel Chlamydia / Gonorrhea / Trichomonas <input type="checkbox"/> Chlamydia & Gonorrhea Screen <input type="checkbox"/> Prenatal Screen <input type="checkbox"/> Vagina ¹ <input type="checkbox"/> Endocervical ² <input type="checkbox"/> Urine, First Catch ³ <input type="checkbox"/> Urethra ² <input type="checkbox"/> Rectal ¹ <input type="checkbox"/> Throat ¹ <input type="checkbox"/> Eye ¹ <input type="checkbox"/> Trichomonas Vaginalis Screen Female ≥ 14Y: <input type="checkbox"/> Vagina ¹ <input type="checkbox"/> Endocervical ² <input type="checkbox"/> Urine, First Catch ³		
				Additional Tests _____ _____ _____		

Transport Device:

¹ Aptima Multitest swab (Orange label, PINK shaft)

² Aptima Unisex swab (White label, BLUE shaft)

³ Aptima Urine Collection kit (Yellow label)



Immunization Record

Central Point Pharmacy, 10382-105 Street NW, Edmonton AB T5J 1E6
Phone: (780) 250-2616 Fax: (780) 250-2617

PATIENT INFORMATION

First Name	Last Name	Gender	DOB	Weight
Address		Health Card #		Phone Number
Emergency Contact	Relationship to Patient	Contact's Phone Number		Contact's Other Phone Number

SCREENING QUESTIONNAIRE

Are you experiencing any cold, flu or COVID-19-like symptoms, even mild ones?	Yes	No	Unsure
Have you travelled to any countries outside Canada (including the United States) within the last 14 days?	Yes	No	Unsure
Did you provide care or have close contact with a person with confirmed COVID-19?	Yes	No	Unsure
Are you allergic to any medications including vaccines?	Yes	No	Unsure
Do you have an allergy to kanamycin, neomycin, gentamicin, thimerosal, chicken protein, polymixin or gelatin?	Yes	No	Unsure
Have you ever had a severe, life threatening reaction to a past vaccination?	Yes	No	Unsure
Have you had wheezing, chest tightness or difficulty breathing within 24 hours of getting a vaccine?	Yes	No	Unsure
Are you allergic to latex gloves?	Yes	No	Unsure
Have you had Guillain-Barre Syndrome within 6 weeks of getting a vaccine?	Yes	No	Unsure
Do you have a new or changing neurological disorder?	Yes	No	Unsure
Do you take a blood thinner or have a bleeding disorder?	Yes	No	Unsure
Pharmacist-Will you be administering a Live Vaccine? (If "No", skip the following questions)	Yes	No	
Do you have a medical condition that can weaken your immune system? (eg. Leukemia, Lymphoma, HIV/AIDs)	Yes	No	Unsure
Are you taking any medications that can weaken your immune system within the past 3 months? (eg Prednisone etc)	Yes	No	Unsure
Have you received any other vaccines in the last 4 weeks?	Yes	No	Unsure
Are you or do you think you might be pregnant?	N/A	Yes	No

CONSENT GIVEN BY PATIENT/AGENT

I, the undersigned client, parent or guardian, have read or had explained to me, information about the vaccine as outlined in the vaccine information sheets provided to me. I have had the chance to ask questions, and answers were given to my satisfaction. I agree to wait in the pharmacy for 15 minutes(or time recommended by the pharmacist) after getting the vaccine. I am aware that it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine. Some serious reactions called "anaphylaxis" can be life-threatening and is a medical emergency. If I experience such a reaction following vaccination, I am aware that it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to try to treat this reaction and that 9-1-1 will be called to provide additional assistance to the immunizer. The symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips. In the event of anaphylaxis, I will receive a copy of this form containing information on emergency treatments that I had received, or a copy will be provided to my agent or EMS paramedics.

☐ I confirm that I want to receive OR ☐ I confirm that I want my child to receive

Product

Patient/Agent & Relationship	Patient/Agent Signature	Date Signed
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PHARMACIST DECLARATION I confirm the above named patient is capable of providing consent for _____ Product _____ and that the _____ Product _____ should be given to patient.

Pharmacist	Pharmacist Signature	Date Signed
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Prescription Authorization

Patient:
Address:
DOB:
Phone:

Engerix-B 20mcg/mL

Generic Name: Hepatitis B Surface Antigen (Recombinant) Disp Qty 1
DIN 02487039 INJECT 1ML INTRAMUSCULARLY (0,1,6 MONTHS)

Approved Qty	<u>1</u>
Repeats	<u>2</u>

MMR II Vaccine 0.5ml

Generic Name: Measles/Mumps/Rubella Virus Vaccine Disp Qty 1
DIN 00466085 INJECT 0.5 ML(S) SUBCUTANEOUSLY (0,28 DAYS)

Approved Qty	<u>1</u>
Repeats	<u>1</u>

Varivax III 1350 Unit/0.5mL

Generic Name: Varicella-Zoster Virus Vaccine Disp Qty 1
DIN 02246081 INJECT 0.5ML SUBCUTANEOUSLY (0, 3 MONTHS)

Approved Qty	<u>1</u>
Repeats	<u>1</u>

Boostrix Publicly Funded

Generic Name: Publicly Funded Tdap Vaccine
DIN 02247600 INJECT 0.5 MLS INTRA MUSCULAR

Approved Qty 1
Repeats

Prescriber Name (print name) Raj Manhas ID # 14127

Prescriber Signature _____ Date _____

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