Last Name teater First Name tesr Salutation Changed Save C

Address 1
Address 2
City Edmonton 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 +

Load Dele

Comments (0) F2 Ins Del

Topic	Comment
Program:	

Student ID:

PHN

Plans (0) F2

SubPlan Code	Group ID	Client ID	Expiry

Record of Immunization Form

Name: teater _____ tesr _____ _____
Last name First Name Middle Initial

Date of birth (MM/DD/YY): _____
Program Name: _____ Program Start Date: _____
Student ID #: _____ Email: _____

Tuberculin Skin Test (TST)

- Single baseline TST must be done within 1 year of program start date. TST must be read 48 to 72 hours later by a qualified provider, not self-read. If you have a Positive TB Skin Test result, you must also submit a chest x-ray result (done within 6 months of program start date.)

☐ Check this box if a TB Skin Test is not required for your program

Date given: _____ Given by: _____
Date read: _____ Read by: _____
Result: ☐ Negative ☐ Positive _____ mm induration

TB Test results MUST BE recorded in both words and numbers (e.g. Negative, 0 mm induration)

CHEST X-RAY (only required for Positive TST)

Date of chest x-ray: _____ Result: _____

ATTACH A COPY OF CHEST X-RAY RESULTS

Varicella

- Documented history of 2 doses of Varicella-containing vaccine **OR**
- Laboratory evidence of immunity **OR**
- Self-reported history or physician diagnosed varicella disease prior to January 2001 **OR**
- Physician diagnosed shingles disease (please provide a letter from your physician)

☐ Check this box if Varicella is not required for your program

Lab evidence of Immunity (titres) Date: _____ Result: ☐ Immune ☐ Not Immune
Varicella vaccine Dose #1: _____ Dose #2: _____
History of Chickenpox ☐ Yes ☐ No Year (if known): _____
History of Shingles ☐ Yes ☐ No ☐ Please provide a letter from physician

Measles, Mumps, Rubella

- Documented history of 2 doses of MMR vaccine. **Serology is not accepted.**

MMR vaccine Dose #1 Date: _____ Dose #2 Date: _____

Td (Tetanus/Diphtheria) Primary Series

- Documentation of a completed Td Primary Series (minimum 3 doses). Reinforcing dose of Tetanus/Diphtheria/Pertussis vaccine within the last 10 years. (Only the dates of the last 3 doses are required for this form.)

Complete Td Primary Series (≥ 3 doses) ☐ Yes ☐ No

Dose #1 Date: _____ Dose #2 Date: _____ Dose #3 Date: _____

Adult Tdap booster (Tetanus/Diphtheria/Pertussis)

- If no documented history of a dose of acellular pertussis vaccine as an adult **(at or over the age of 18)**: 1 dose of Tdap (Adacel or Boostrix vaccine), **regardless of the interval since the last dose of tetanus containing vaccine.**

Tdap Adult booster ☐ Adacel vaccine ☐ Boostrix vaccine Date: _____

Hepatitis B Series

- Documentation of a completed Hepatitis B Series. (An alternative adolescent schedule of 2 doses of 1.0 mL administered on day 0 and 6 months later is also acceptable.)

☐ Check this box if Hepatitis B is not required for your program

Complete Hepatitis B Series ☐ Yes ☐ No

Dose #1 Date: _____ Dose #2 Date: _____ Dose #3 Date: _____

Hep B Booster dose(s) if necessary

Booster #1 Date: _____ Booster #2 Date: _____ Booster #3 Date: _____

Hepatitis B Post-Immunization Serology

- Hepatitis B post-immunization serology should be completed 1 to 6 months after completion of the Hep B series **or** at the time of assessment.

Lab evidence of Hep B Immunity *(Hep B Surface Antibody)* Date: _____ Result: ☐ Immune ☐ Not Immune

Titres *(if known)*: _____ IU/L

Polio Primary Series

- Documentation of a completed Polio Primary Series (minimum 3 doses).

☐ Check this box if Polio is not required for your program

Complete Polio Primary Series (≥ 3 doses) ☐ Yes ☐ No

Dose #1 Date: _____ Dose #2 Date: _____ Dose #3 Date: _____

Adult Polio booster

- One reinforcing dose of Polio received at **18 years of age or older** and at least 10 years after the primary series.

☐ Check this box if Polio is not required for your program

Adult Polio booster Booster Date: _____

Healthcare Professional Verification

This verifies the above individual has completed the **first doses** of all the recommended immunizations for their program, including a **TB Skin Test**, if applicable.

This verifies the above individual has completed **all** the recommended immunizations for their program and has been sent for **Post Hepatitis B Immunization serology**, if applicable.

Health Practitioner Signature: _____

Date: _____
Health Unit Stamp

Health Practitioner Signature: _____

Date: _____
Health Unit Stamp

School Verification *(NAIT use only)*

Nurse Signature: _____ Nurse Signature: _____

TB Mantoux Skin Test Intake Form

First Name: tesr **Last Name:** teater **Date:**

Cell Phone Number: **DOB:** **AHC #:**

Address: **City** Edmonton **Prov:** AB

Emergency Contact Name & Phone Number:

Do you take any medications:

Allergies: **Email:**

Check all that apply:

- ☐ Coughing for three or more weeks
- ☐ Coughing up blood or mucus
- ☐ Chest pain, or pain with breathing or coughing
- ☐ Unintentional weight loss
- ☐ Fatigue
- ☐ Fever, Night sweats or Chills
- ☐ Loss of appetite
- ☐ Live or are from a country where TB is common (Latin America, Africa and Asia)
- ☐ In contract with people who have TB or treat people with high risk.
- ☐ Have had the BCG (Bacille Calmette-Guerin vaccine) vaccine, sarcoidosis, or Hodgkin's lymphoma
- ☐ Have HIV/AIDs or a positive test result before
- ☐ Have had one or more of the following vaccines in the past 4 weeks: four weeks AFTER a Covid, MMR or Chickenpox vaccine
- ☐ None of the above

I consent to having a Mantoux Tuberculin Skin Test (TST) done, to wait 15 minutes after so that any allergic reactions can be monitored, & agree to having my personal health information shared with public health officials and other healthcare providers. *

○ Yes, I consent Signature:

○ No

I understand that I am responsible for booking a follow up appointment within 48 – 72 hours following my test. If I do not then the test must be repeated. *

○ Yes, I agree Signature: _____

○ No

OFFICE USE ONLY

Test Date:_____ Reading Date:_____

Time: READING Time:

TUBERSOL (DIN:00317268) – Sanofi Pasteur Reading: _____mm

LOT:_____

EXPIRY:_____ Initial: _____

Initial: _____Site: Right/Left Forearm

GENERAL LABORATORY REQUISITION

DynaLIFE MEDICAL LABS

Appointment Booking & Locations: www.dynalife.ca or www.albertaprecisionlabs.ca
Access to Test Results: www.alberta.ca/mhr
*Dyna***LIFE** Medical Labs: **1 (800) 661-9876** or **(780) 451-3702**
Alberta Precision Laboratories: **1 (877) 868-6848**

Scanning Label or Accession # *(lab only)*

Patient

PHN / Healthcare Number Expiry:_____ | Alternate Identifier

Legal Last Name: teater | Legal First Name: tesr | Middle Name | Date of Birth *(dd-Mon-yyyy)*

Preferred Name | ☒ Male ☐ Female ☐ X (Non-Binary/Prefer not to Disclose) | Phone

Address | City / Town: Edmonton | Province: AB | Postal Code

Provider(s)

Authorizing Provider Name *(Last, First, Middle)*: Manhas, Raj

Address: 10382 105 ST NW, EDMONTON T5J 1E6

CC Provider ID: 2866 | CC Submitter ID: 12047 | Legacy ID

Clinic / Building Name: Central Point Pharmacy

Copy To 1

Authorizing Provider Name *(Last, First, Middle)*

Address

Phone

Clinic / Building Name

Copy To 2

Authorizing Provider Name *(Last, First, Middle)*

Address

Phone

Clinic / Building Name

Collection

Date *(dd-Mon-yyyy)* | Time *(24h)* | Location | Collector ID

☐ Routine ☐ Stat | Requisition Date

***F** Denotes a **fasting test**
***I** Special instructions, see website

Hours Fasting _____

☐ Third Party Bill? Client _____

Hematology / Coagulation

☐ CBC and Differential ☐ CBC no Differential
☐ D-dimer
☐ Fibrinogen
☐ INR
☐ Reticulocyte Count

General Chemistry

☐ Albumin
☐ Alkaline Phosphatase (ALP)
☐ Alanine Aminotransferase (ALT)
Bilirubin: ☐ Total ☐ Total and Conjugated
☐ Calcium
☐ C-Reactive Protein (CRP)
☐ Creatine Kinase (CK)
☐ Creatinine (eGFR)
Electrolytes: ☐ Sodium ☐ Potassium
☐ Ferritin
☐ Gamma Glutamyl Transferase (GGT)
☐ Glucose Fasting ***F** ***I**
☐ Glucose Random
☐ Hemoglobin A1c
☐ HCG, Serum (Quantitative)
Immunoglobulins: ☐ A (IgA) ☐ G (IgG) ☐ M (IgM)
☐ Lipase
☐ Magnesium
☐ Phosphate
☐ Prostate Specific Antigen (PSA)
☐ Protein Electrophoresis-Serum
☐ Total Protein
☐ Urate

☐ Lipid Panel ☐ Cholesterol ☐ Triglycerides
☐ Cardiovascular Disease Risk Assessment *(includes Lipid Panel)*

Required History:

Systolic Blood Pressure (mmHg) _____
Tobacco Use ☐ Yes ☐ No
Treated for High blood pressure ☐ Yes ☐ No
Diabetic ☐ Yes ☐ No
Chronic Kidney Disease ☐ Yes ☐ No
Atherosclerosis ☐ Yes ☐ No
First Degree Relative with CVD (M<55Y / F<65Y) ☐ Yes ☐ No

Glucose Tolerance Tests

☐ Glucose, Gestational Diabetes Screen (GDS)
☐ Glucose Tolerance, Gestational, 2h ***F** ***I**
☐ Glucose Tolerance, 2h ***F** ***I**

Miscellaneous

☐ FIT Colorectal Cancer Screening (Age 50-74) ***I**
☐ H. pylori ***I**
☐ Hemoglobinopathy Investigation

Endocrinology

Cortisol:
☐ Random ☐ AM (0700-1000) ☐ PM (1500-1800)
☐ Estradiol
☐ Follicle Stimulating Hormone (FSH)
☐ Luteinizing Hormone (LH)
☐ Parathyroid Hormone (PTH)
☐ Progesterone
☐ Prolactin
☐ Testosterone, Total
☐ Thyroid Stimulating Hormone (TSH)
☐ Thyroid Stimulating Hormone (TSH), Progressive

Immunology / Serology

☐ Epstein - Barr Virus Serology - IgM
☐ Hepatitis A Virus Acute Serology - IgM
☐ Hepatitis A Virus Immunity Serology - IgG
☒ Hepatitis B Surface Antigen
☒ Hepatitis B Surface Antibody
☐ Hepatitis C Virus Serology
☐ HIV 1 and 2 Serology (Antigen and Antibody)
☐ Mononucleosis Screen
☐ Rheumatoid Factor
☐ Rubella Immunity Serology - IgG
☐ Syphilis

Cardiology

☐ Electrocardiogram
ECG to be read by:
☐ DynaLIFE Panel ☐ Other _____

Transfusion Medicine

☐ Direct Antiglobulin Test (DAT)
☐ RHIG Eligibility, Prenatal
Type & Screen - separate process required, contact lab
Prenatal Type & Screen - use CBS Perinatal Requisition

Sterile Body Fluid

☐ Fluid Type _____ Source _____
Test(s) _____

Urine

☐ Urinalysis

Albumin (Creatinine Ratio)	☐ Random	☐ 24h
Creatinine	☐ Random	☐ 24h
Cortisol		☐ 24h
Protein Electrophoresis	☐ Random	☐ 24h
Total Protein (Creatinine Ratio)	☐ Random	☐ 24h

☐ Creatinine Clearance 24h Ht ____ cm Wt ____ kg

24h Urine ***I***

Total Volume _____
Start Date _____ Start Time _____
End Date _____ End Time _____

Clinical Information

Drug Levels / Monitoring

☐ Ethanol Level, Blood

Therapeutic Drug Monitoring:

Dose Route ☐ Oral ☐ IV ☐ 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 _____
☐ Carbamazepine ☐ Phenytoin, Total
☐ Cyclosporine Pre Dose ☐ Sirolimus
☐ Cyclosporine 2h Post ☐ Tacrolimus
☐ Digoxin ☐ Theophylline
☐ Lithium ☐ Valproate
☐ Phenobarbital ☐ Other _____

Antibiotics:

Gentamicin ☐ Pre ☐ Post ☐ Interval ☐ Other
Tobramycin ☐ Pre ☐ Post ☐ Interval ☐ Other
Vancomycin ☐ Pre ☐ Other

Urine Drug Testing Panels

Reason for Request _____
☐ Opioid Dependency Panel
What is the Treatment Regimen?
☐ Buprenorphine ☐ Methadone
☐ Morphine ☐ Hydromorphone
☐ Other _____
OR
☐ General Toxicology Panel

Chlamydia / Gonorrhea / Trichomonas

☐ Chlamydia & Gonorrhea Screen ☐ Prenatal Screen
☐ Vagina[1]
☐ Endocervical[2]
☐ Urine, First Catch[3]
☐ Urethra[2] ☐ Rectal[1]
☐ Throat[1] ☐ Eye[1]

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)

☐ Trichomonas Vaginalis Screen
Female ≥ 14Y:
☐ Vagina[1] ☐ Endocervical[2] ☐ Urine, First Catch[3]

Additional Tests

VZV IgG
anti-HBc total

CENTRALPOINT PHARMACY

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*
tesr	teater			
Address		*Health Card #*		*Phone Number*
Edmonton				
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*	*Unsure*

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*

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*

Prescription Authorization

Patient: tesr teater
Address: Edmonton
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 1
Repeats 2

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 1
Repeats 1

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 1
Repeats 1

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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