Last Name | First Name | 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 |
|---|---|---|---|
| | | | |

MacEwan UNIVERSITY | FACULTY OF NURSING

# Record of Immunization

**NAME:** _____ **DOB:** _____
(PLEASE PRINT) Last Name First Name Middle Initial DD / MMM / YYYY

**Home or Cell number:** _____ **Student ID #:** _____

**School:** _MACEWAN UNIVERSITY_ **PROGRAM:** _____ **Start Date:** _____

| TETANUS, DIPHTHERIA & PERTUSSIS | MEASLES, MUMPS & RUBELLA | VARICELLA | COVID – 19 Not Mandatory |
|---|---|---|---|
| Dates of primary series:<br>#1 _____<br>#2 _____<br>#3 _____<br><br>Booster:<br>Td/dTap: _____<br>(Circle one) (Date) | MMR Dates:<br>#1 _____ (Date)<br>#2 _____ (Date)<br><br>Measles:<br>Date: _____<br><br>Mumps:<br>Date: _____<br><br>Rubella:<br>Date: _____ | ☐ Had Disease<br>Immunization Dates:<br>#1 _____ (Date)<br>#2 _____ (Date)<br><br>☐ Positive Serology on:<br>Date: _____<br><br>☐ Sent for Serology on:<br>Date: _____ | #1 _____ (Date)<br>#2 _____ (Date)<br>#3 _____ (Date)<br>#4 _____ (Date) |

| HEPATITIS B | | INFLUENZA |
|---|---|---|
| **MANDATORY FOR NURSING PROGRAMS**<br><br>Dates of Primary HEP B series:<br>#1 _____ (Date)<br>#2 _____ (Date)<br>#3 _____ (Date) | Booster (s) if necessary:<br>Date: _____<br>Date: _____<br>Date: _____<br><br>MANATORY HEP B SEROLOGY<br>☐ Positive Serology on:<br>Date: _____<br>☐ Sent for Serology on:<br>Date: _____<br>Results will be mailed to student<br>☐ HEP B Vaccine not recommended for student | Immunized: _____ (Date)<br><br>Decline: _____ (Date) |

## TB / Mantoux Skin Test

**Mandatory for Nursing Program** (must be within 12 months of admission date)

☐ Previous positive – Sent for chest x-ray: _____
(Results will be mailed to student) Date

**TB Testing:**
1st test _____ (Date) Read: _____ (Date) Result: _____ mm
2nd test _____ (If required) (Date) Read: _____ (Date) Result: _____ mm

**Follow-up:**
Sent for chest x-ray: Date: _____
(Results will be mailed to student)

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

# Record of Immunization – Page 2

**NAME:**_____ **Student ID #:** _____
**Last Name** **First Name** **Middle Initial**

**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

_____ _____
Health Care Professional Signature Date

This verifies the above individual has completed the **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

_____ _____
Health Care Professional Signature Date

# TB Mantoux Skin Test Intake Form

**First Name:** _____ **Last Name:** _____ **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

DynaLIFE MEDICAL LABS

# GENERAL LABORATORY REQUISITION

**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 | Legal First Name | 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* |
|---|---|---|---|---|
| *Address* Edmonton | | *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* | *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:
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 _____

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