PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

Version: December 24, 2021

Third/Fourth Dose or Re-Immunization COVID-19 Vaccine Referral Form

If you are unable to administer the COVID-19 vaccine to your eligible patients, please complete and sign this form to refer them to a Wellington-Dufferin-Guelph Public Health clinic. Patients must bring this completed and signed form to their vaccine appointment. Fax this referral form to 1-855-934-5463 and your patient will be directly contacted by public health to book their appointment.

Last Name	**First Name**	**Health Card No.**
Date of Birth MM / DD / YYYY	**Name of Referring Physician**	
Home/Mobile Phone	**Email address**	

COMPLETE THIS SECTION FOR REFERRALS FOR THIRD OR FOURTH DOSE

Referral for: ☐ **Third Dose (3-Dose Primary Series)** ☐ **Fourth Dose (Booster following 3-Dose Series)**

Reason for third/fourth dose of COVID-19 vaccine*:

- ☐ Receiving active treatment (e.g., chemotherapy, targeted therapies, immunotherapy) for solid tumour or hematologic malignancies *(Active treatment includes patients who have completed treatment within 3 months)*
- ☐ Recipient of solid-organ transplant and taking immunosuppressive therapy
- ☐ Recipient of chimeric antigen receptor (CAR)-T-cell therapy or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy)
- ☐ Moderate to severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)
- ☐ Stage 3 or advanced untreated HIV infection and/or acquired immunodeficiency syndrome
- ☐ Receiving active treatment with the following categories of immunosuppressive therapies: anti-B cell therapies (monoclonal antibodies targeting CD19, CD20 and CD22), high-dose systemic corticosteroids (refer to the CIG for suggested definition of high dose steroids), alkylating agents, antimetabolites, or tumor-necrosis factor (TNF) inhibitors and other biologic agents that are significantly immunosuppressive *(Active treatment for patients receiving B-cell depleting therapy includes patients who have completed treatment within 12 months)*
- ☐ Receiving dialysis (hemodialysis or peritoneal dialysis)

COMPLETE THIS SECTION FOR REFERRALS FOR RE-IMMUNIZATION

Reason for re-immunization with a new COVID-19 vaccine series*:

- ☐ Loss of immunity following hematopoietic stem cell transplant (HSCT) or hematopoietic cell transplant (HCT) (autologous or allogeneic)
- ☐ Loss of immunity following chimeric antigen receptor (CAR)-T-cell therapy

Patient is homebound and requires a home visit to receive vaccine: ☐ **Yes** ☐ **No**

- ☐ I have provided counselling regarding the risks, benefits, and timing of additional vaccine dose(s) in accordance with provincial guidance.

Physician Signature:

***Individuals must have one of the health conditions listed. Referrals with other health conditions or criteria will not be accepted.**