PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

Version: Apr 22, 2021

COVID-19 Vaccine Referral Form

Complete this form for any patients referred for pregnancy (first dose) OR exception to the delayed second dose interval for COVID-19 vaccines (due to specific health condition).

Last Name	**First Name**	**Health Card No.**
Date of Birth MM / DD / YYYY	**Primary Care Provider**	
Home Phone	**Mobile Phone**	**Email address**
COMPLETE THIS SECTION FOR REFERRALS FOR PREGNANCY (FIRST DOSE) **Pregnancy Due Date:** MM / DD / YYYY		
COMPLETE THIS SECTION FOR REFERRALS FOR EXCEPTION TO EXTENDED DOSE INTERVAL **Received first dose:** ☐ **Yes** ☐ **No** ☐ **Not Sure** **Reason for exception to extended vaccine dose interval:** ☐ Transplant recipient (including solid organ transplants and hematopoietic stem cell transplants) ☐ Individual with malignant hematologic disorder or non-hematologic malignant solid tumor receiving active treatment (chemotherapy, target therapies, immunotherapy)		

Last Name	**First Name**	**Health Card No.**
Date of Birth MM / DD / YYYY	**Primary Care Provider**	
Home Phone	**Mobile Phone**	**Email address**
COMPLETE THIS SECTION FOR REFERRALS FOR PREGNANCY (FIRST DOSE) **Pregnancy Due Date:** MM / DD / YYYY		
COMPLETE THIS SECTION FOR REFERRALS FOR EXCEPTION TO EXTENDED DOSE INTERVAL **Received first dose:** ☐ **Yes** ☐ **No** ☐ **Not Sure** **Reason for exception to extended vaccine dose interval:** ☐ Transplant recipient (including solid organ transplants and hematopoietic stem cell transplants) ☐ Individual with malignant hematologic disorder or non-hematologic malignant solid tumor receiving active treatment (chemotherapy, target therapies, immunotherapy)		

Completed forms can be faxed to **1-855-934-5463**