Immunisation Program Vaccine Order Form

Queensland Government

Ph: 3328 9888 Fax no.: 3328 9720
Email: QHIP-ADMIN@health.qld.gov.au

Vaccines will be provided monthly

PRACTICE DETAILS (Please print all information)	**VSP Number:**	**Date:** ____ /____ / 201____
VSP Name:		
Address:		
Telephone no:	**Fax no.:**	**Practice contact person:**

Have your vaccine refrigerator temperatures been between +2°C and +8°C since your last vaccine order? **YES** ☐ *or* **NO** ☐
If **NO** *contact the Immunisation Program as soon as possible during business hours on 3328 9888*

Phone the Immunisation Program for **refugee vaccine** orders and all orders following **cold chain breaches that involved discarded vaccine**

Vaccine Name	Program	TOTAL Quantity on Hand	Vaccine Expiry Date/s	Quantity Required
Infanrix Hexa DTPa-hep B-IPV-Hib	Childhood – 6 weeks, 4 & 6 months			*Office use only*
Prevenar 13 Pneumococcal (13vPCV)	Childhood – 6 weeks, 4 & 6 months Childhood – ATSI 12 & 18 months			*Office use only*
RotaTeq (oral) Rotavirus	Childhood – 6 weeks, 4 & 6 months			*Office use only*
Menitorix Hib-MenCCV	Childhood – 12 months			*Office use only*
Infanrix IPV DTPa/IPV	Childhood – 4 yrs			*Office use only*
Priorix or M-M-R II MMR - Measles-mumps-rubella	Childhood – 12 months; 4 yrs *No Jab No Pay* Refugees			*Office use only*
Priorix-tetra or ProQuad MMRV - Measles-mumps-rubella & Varicella	Childhood – 18 months; 4 yrs			*Office use only*
DTPa (brands to be advised)	Childhood – 18 months			*Office use only*
Vaqta Paediatric Hepatitis A	Childhood – ATSI 12& 18 months; catch up <10yrs			*Office use only*
Pneumovax 23 Pneumococcal (23vPPV)	Adult – 65+ years; ATSI 50+ yrs			
Influenza vaccine	Adult			
	Paediatric			
HBVaxII *paediatric* Hepatitis B	Birth dose – maternity hospitals *No Jab No Pay* Refugees			
Adacel dTpa	Pregnant women during 3rd trimester			
Boostrix dTpa	School Immunisation Program catch up *No Jab No Pay* Refugees			
Gardasil Human Papillomavirus	School Immunisation Program catch up only			
Varilrix or Varivax Varicella	School Immunisation Program catch up *No Jab No Pay*			
ADT or dT dT	*No Jab No Pay* Refugees			
Boostrix IPV or Adacel IPV dTpa-IPV	*No Jab No Pay*			
HBVaxII *Adult* Hepatitis B	ATSI; at Risk Clients; Ethnicity *No Jab No Pay* Refugees			
IPOL Inactivated poliomyelitis	*No Jab No Pay* Refugees			
NeisVac-C Meningococcal C	*No Jab No Pay*			
Other				
Other				

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Patient details for additional catch-up vaccines

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- **To be completed when requesting any Funded Vaccines for catch-up**
- **For prompt processing please fill out all fields; place N/A where not applicable**
- **Check vaccination records on ACIR or contact your Local PHU to check vaccination records of patients listed below**
- **ADDITIONAL VACCINE/S WILL ONLY BE SUPPLIED with YOUR Monthly Vaccine Order**

PRACTICE DETAILS (Please print all information)	**VSP Number:**	**Date:** ____ /____ / 201____
VSP Name:		

Ensure all immunisations are recorded and forwarded as per your usual practice (at least weekly)

Surname (family name):				**Date of Birth:**		
Given Name:						
Reason for request : ☐ Catch up School Immunisation Program (SIP) vaccination ☐ *No Jab, No Pay – 10 to 19 year olds* ☐ Catch up less than 10 years ☐ Inappropriate schedule for vaccination e.g doses too close, incorrect vaccination given				**School Year level**: *Must be completed if requesting School Immunisation Program vaccine to determine eligibility*		
Vaccine/s Required:						
Dose Number:						

Surname (family name):				**Date of Birth:**		
Given Name:						
Reason for request : ☐ Catch up School Immunisation Program (SIP) vaccination ☐ *No Jab, No Pay – 10 to 19 year olds* ☐ Catch up less than 10 years ☐ Inappropriate schedule for vaccination e.g doses too close, incorrect vaccination given				**School Year level**: *Must be completed if requesting School Immunisation Program vaccine to determine eligibility*		
Vaccine/s Required:						
Dose Number:						

Surname (family name):				**Date of Birth:**		
Given Name:						
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Dose Number:						