Public Health
Santé publique
SUDBURY & DISTRICTS

AUTHORIZING
ORGANIZATION / PHYSICIAN
CONTACT INFO

COVID-19 VACCINE FOUTH DOSE

PHYSICIAN OR HOSPITAL SPECIALTY PROGRAM

PATIENT REFERRAL FORM:

Important to Note:

- Referral form to be completed ONLY when vaccination administration is unable to be completed intra-organizationally by Physician or Specialty Program responsible for eligible patient care.
- To refer an eligible candidate for a 4th dose or booster dose of the COVID-19 vaccine, this form must be COMPLETED IN FULL, signed, and shared with the patient.
- Upon completion, this form must be provided to eligible patients either in print or digitally in .pdf.
- This form OR proof of eligibility MUST be presented when attending their vaccination appointment.

Patient Name: _____

Date: _____/____/_____
MM DD YYYY

Patient Address: _____

Patient Health Card Number: _____

Based on the recommendation of the Chief Medical Officer of Health and health experts, Ontario is offering fourth doses of the COVID-19 vaccine to select vulnerable populations which may be required to provide sufficient protection based on a suboptimal or waning immune response to vaccines and increased risk of COVID-19 infection.

PATIENT ELIGIBILITY:

Please review the Ministry of Health's COVID-19 vaccine third dose and booster recommendations to identify patient eligibility for a 4th or booster dose of the COVID-19 vaccine. Indicate the relevant condition below:

_____

VACCINATION LOCATIONS AND PATIENT INSTRUCTIONS:

Call 705.522.9200 (toll-free: 1.866.522.9200),
between 8:30 a.m. and 4:30 p.m., Monday to Friday.
or **visit www.phsd.ca**

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PATIENT-SPECIFIC TREATMENT CONSIDERATIONS AND SCHEDULING:

Please Note: 3rd dose vaccinations can be administered no earlier than 8 weeks (or 56 days) after second dose for those who qualify. A fourth or booster dose vaccination can be administered ≥3 months (84 days) after completion of a primary COVID-19 vaccine series.

CONDITION-SPECIFIC TREATMENT NEEDS:

☐ No treatment considerations
(May book as appropriate after third dose)

☐ Yes, treatment must be considered.
Specific scheduling requirements:

_____

DOSE VACCINATION SCHEDULE & TYPE(S):

First Dose:
Vaccine Type: _____
Date: _____/____/_____ (MM / DD / YYYY)

Second Dose:
Vaccine Type: _____
Date: _____/____/_____ (MM / DD / YYYY)

Third Dose:
Vaccine Type: _____
Date: _____/____/_____ (MM / DD / YYYY)

Physician Name: _____ CSPO#: _____ Signature: _____

I have provided counselling regarding the risks, benefits, and timing of a 4th dose of COVID-19 vaccine in accordance with provincial guidance.
By signing, I confirm the information above to be true and accurate to the best of my knowledge.