

VACCINE REQUEST FORM

Enquiries: QHIP  
Telephone: 3328 9888  
Facsimile: 3328 9720

Practice/Organisation

Date: \_\_\_\_/\_\_\_\_/201\_\_ VSP No.

VSP Name: .....

Address: ..... Post code:.....

Telephone: ..... Fax No.: .....

Have vaccine fridge temperatures been between +2°C and +8°C since last vaccine order?  
 YES  NO

Please print contact name ..... Practice/organisation contact: .....  
(Signature)

NB: To avoid any delays ensure all parts of this form are completed

It is important to provide an accurate count of ALL QHIP stock (*Quantity on Hand*) in your fridge with each order – failure to do so will delay the processing of your order.

Check and record expiry dates of vaccines and rotate shortest expiry dates to be used first.

Vaccine Type	Quantity on Hand	Expiry Date of Vaccine
<b>Infanrix Hexa™</b> DTPa-hepB-IPV-Hib Diphtheria-tetanus-acellular pertussis, Hepatitis B, <i>Haemophilus influenzae</i> type b, inactivated poliomyelitis vaccine		
<b>Prevenar™ (7vPCV)</b> Infant Pneumococcal vaccine		
<b>RotaTeq™ (oral)</b> Rotavirus vaccine		
<b>Hiberix™</b> <i>Haemophilus influenzae</i> type b vaccine		
<b>Meningitec™/NeisVac-C™</b> Meningococcal C conjugate vaccine		
<b>Infanrix IPV™</b> DTPa - Diphtheria-tetanus-acellular pertussis-inactivated poliomyelitis vaccine		
<b>Priorix™</b> Measles, Mumps, Rubella vaccine		
<b>Varilrix™</b> Varicella vaccine		
<b>VAQTA™</b> Hepatitis A – paediatric vaccine		
<b>Pneumovax23™</b> Pneumococcal vaccine		
<b>Other</b>		
<b>Other</b>		

Vaccine Type	Quantity on Hand	Expiry Date of Vaccine
<i>Targeted Program Requirements</i>		
* <b>Boostrix / Adacel™</b> (Parents only) Diphtheria, tetanus, acellular pertussis adult formulation vaccine	Qty on Hand _____ Expiry Date ____/____/____	Qty Required
* <b>HBVaxII™ – Paediatric</b> Hepatitis B vaccine-paediatric dose <i>Please note supporting documentation required</i>	Qty on Hand _____ Expiry Date ____/____/____	Qty Required
<i>School Based Program</i> Please note supporting documentation required		
* <b>Boostrix™</b> Diphtheria, tetanus, acellular pertussis adult formulation vaccine	Qty on Hand _____ Expiry Date ____/____/____	Qty Required
* <b>Gardasil™</b> Human Papillomavirus vaccine	Qty on Hand _____ Expiry Date ____/____/____	Qty Required
* <b>HBVaxII™ – Adult</b> Hepatitis B vaccine adult dose	Qty on Hand _____ Expiry Date ____/____/____	Qty Required
<p>* <b>Please indicate quantity required (including NIL) where requested</b> – and include separate sheet with patient details if necessary.</p> <p>* Vaccine will only be provided in your standard monthly order. <b>Name, date of birth and year level of children to be vaccinated must be supplied.</b></p> <p>* Vaccine will be replaced where private stock has been used on presentation of eligible vaccination details including <b>name, date of birth and year level of children, plus date of vaccination.</b></p>		