Janeway RSV Immunization Program Referral Form

This referral form is for children less than 2 year old who may be eligible for RSV immunization for their second RSV season

Date of Referral:

Patient Information:

Birth Weight (grams):

Gestational Age: (weeks)

MCP:

Date of Birth:

Parent/Guardian Contact Information

Last Name:

First Name:

Address:

City:

Province:

Postal Code:

Telephone Number:

Referring Physician Information

Name:

Email Address:

Address:

Telephone: Number:

Eligibility Criteria:

- ☐ Chronic lung disease, including bronchopulmonary dysplasia, requiring ongoing assisted ventilation, oxygen therapy or chronic medical therapy in the 6 months prior to the start of the RSV season (November to May)
- ☐ Cystic fibrosis with respiratory involvement and/or growth delay
- ☐ Hemodynamically significant chronic cardiac disease
- ☐ Severe congenital airway anomalies impairing clearing of respiratory secretions
- ☐ Neuromuscular disease impairing clearing of respiratory secretions
- ☐ Severe immunodeficiency and people living with HIV with CD4 less than 750 cells/µL if they are less than 1 year old or CD4 less than 500 if they are between 1 to 2 years old.

Other:

(The "Other" category requires a letter from the referring physician providing medical justification for request)

Request for access to publicly funded RSV prophylaxis is subject to approval by the Newfoundland and Labrador RSV Prevention Program

Email (Preferred): rsv.program@nlhealthservices.ca **Fax: 709-777-4178**

For Office Use only

☐ **Approved** ☐ **Not Approve**

Name: **Date:**

Signature: