COVID-19 Primary Series Re-Vaccination
Lakeridge Health Immunization Clinic (Durham Public Health)
Patient Referral Form

- **Once completed please fax to 905-721-4876; the clinic will contact the patient to schedule an appointment**
- Walk-in patients with the form in hand will not be accepted; the form must be faxed by the primary care provider/specialist office

Date: ____

Patient Name: ____Date of Birth: __________________________

Health Card Number: ______________________________Patient Phone Number: ____________________

Patient email address: ____

Patient Eligibility:
This patient required re-vaccination of their COVID-19 primary series due to (please check one of the following):

❑ Hematopoietic stem cell transplants (HSCT)

❑ Hematopoietic cell transplants (HCT) (autologous or allogeneic)

❑CAR-T-cell therapy

Re-vaccination is recommended on or after the following date: _____________________________________

Prescriber Name & Registration Number: ____

Prescriber's contact phone number: ____

Signature: ____
By signing, I confirm the information above to be true and accurate to the best of my knowledge.