

Referral for BCG Vaccination

A CHILD WHO HAS RECEIVED A PREVIOUS BCG VACCINATION IS NOT ELIGIBLE

CHILD'S INFORMATION

Child's name:
SURNAME FIRST NAME

NHI: Gender: ☐ Male ☐ Female

Date of birth: Ethnicity:

GUTHRIES TEST: NEGATIVE ☐ Yes ☐ No

RECEIVED A PREVIOUS BCG VACCINATION: ☐ Yes ☐ No

MOTHER'S INFORMATION

Mother's name:

Home address:

Telephone:
HOME MOBILE

Email:

Ethnicity: Interpreter required: ☐ Yes ☐ No language:

HIV POSITIVE: ☐ Yes ☐ No IMMUNOSUPPRESSANT DRUGS DURING PREGNANCY: ☐ Yes ☐ No

General Practitioner:

Referred by: ☐ LMC ☐ GP ☐ Well Child ☐ Self ☐ Relative ☐ CPH

Referrer:
NAME PHONE

Referral date:

CRITERIA

Babies or children less than five years of age are eligible for BCG vaccination if they meet the following:

- They will be living in a house with a family/whānau member who has a history of tuberculosis (TB) ☐ Yes ☐ No
- They have one of both parents or household members or carers, who within the last 5 years, lived for a period of 6 months or longer in countries with a TB rate > 40 per 100,000. ☐ Yes ☐ No
List available online at: <http://www.cdhb.health.nz/Hospitals-Services/Community-Rural-Health-Services/phns/Pages/BCG-Vaccination.aspx>
- During their first 5 years will be living for 3 months or longer in a country with a TB rate of > 40 per 100,000 ☐ Yes ☐ No

If any of the above are marked YES this baby is at higher risk of being exposed to TB and BCG vaccination is recommended

PLEASE EMAIL THIS FORM TO bcbg@cdhb.health.nz

BCG Clinic, Public Health Nursing Service, Private Bag 4708, Christchurch 8140
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