Canterbury District Health Board
Te Poari Hauora ō Waitaha
CHRISTCHURCH HOSPITAL
PUBLIC HEALTH NURSING SERVICE

SURNAME ..... NHI .....
FIRST NAME ..... DOB .....
ADDRESS .....
..... POSTCODE .....
(or affix patient label)

Referral for BCG Vaccination

CHILD'S INFORMATION

Child's name: ..... SURNAME ..... FIRST NAME

NHI: ..... **Gender:** ☐ Male ☐ Female

Date of birth: ..... **Ethnicity:** .....

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

MOTHER'S INFORMATION

Mother's name: .....

Home address: .....

Telephone: ..... HOME ..... MOBILE

Email: .....

Ethnicity: .....

Interpreter required for the clinic: ☐ Yes ☐ No *If yes,* what 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.
  List available online at: http://www.cdhb.health.nz/Hospitals-Services/Community-Rural-Health-Services/phns/Pages/BCG-Vaccination.aspx ☐ Yes ☐ No
- 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 bcg@cdhb.health.nz OR FAX TO (03) 383 6878

BCG Clinic, Public Health Nursing Service, Private Bag 4708, Christchurch 8140
Ph: (03) 383 6863 Fax: (03) 383 6878 Mobile: 021 5700 95

REFERRAL FOR BCG VACCINATION

C270116