R



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:	nale	
Date of birth:		Ethnicity:		
A CHILD WHO HAS RECEIVED A PREVIOUS BCG VACCINATION IS NOT ELIGIBLE				
MOTHER'S IN	FORMATION			
Mother's name:				
Home address:				
Telephone:				
-	HOME	MOBILE		
Email:				
Ethnicity:				
Interpreter required	for the clinic: Yes No If yes, v	vhat language:		
HIV positive:	es 🗌 No 💮 Imm	unosuppressant 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 ☐ No ☐ Yes ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ Yes ☐ No ☐ Yes ☐			☐ 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/Phosphases/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 ☐ Yes ☐ No 100,000.				
If any of the above are marked YES this baby is at higher risk of being exposed to TB and BCG vaccination is recommended				

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

PLEASE EMAIL THIS FORM TO bcg@cdhb.health.nz OR FAX TO (03) 383 6878