



# WA Pandemic H1N1 Influenza Immunisation Program

Fax To: (08) 9388 4820

Practice Name: \_\_\_\_\_ Date: / /

Telephone: \_\_\_\_\_

Practice No \* (Metro only) \_\_\_\_\_

Facsimile: \_\_\_\_\_

Region: (please circle) Great Southern Goldfields Kimberley Mid-West Pilbara Wheatbelt South-West

\* (CSL Practice Number is required for processing of vaccines)

Number of Pages in this fax: \_\_\_\_\_

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	FIRST NAME  (Please print legibly)	SURNAME  (Please print legibly)	PATIENT'S POSTAL CODE	SEX M/F	Date of Birth  ____/____/____	Aboriginal  <input type="checkbox"/> Yes <input type="checkbox"/> No	Indication for Vaccination				Date Vaccine Given  ____/____/09	Batch No of Pandemic Flu Vaccine
							Pregnant  <input type="checkbox"/> Yes <input type="checkbox"/> No	Health Care Worker  <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical Risk Factor  <input type="checkbox"/> Yes <input type="checkbox"/> No	Other  <input type="checkbox"/> Yes <input type="checkbox"/> No		
1					____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/09	
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11					____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/09	
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