DATE: ________________________

RE: COVID-19 VACCINE THIRD DOSE

Patient Name: ____

Patient Health Card Number: __________________________________

Patient Address: ____

I confirm that Mr./Mrs _____________________ (patient name) meets one or more of the criteria below to receive a third dose of the COVID-19 vaccine **and** it has been more than 8 weeks since they received their second dose.

- Transplant Recipient (Including: solid organ transplant and hematopoietic stem cell transplant)
- Patient with Hematological Cancer(s) and on Active Treatment for Malignant Hematologic Disorders (Disorders including: Lymphoma, Myeloma, Leukemia) (Treatments including: Chemotherapy, Targeted Therapies, Immunotherapy)
- Current Recipient of an anti-CD20 Agent (Including: Rituximab, Ocrelizumab, Ofatumumab) Include IF APPLICABLE: Treatment must be Considered. Specific Scheduling Requirements: ____________________

I have provided counselling regarding the risks, benefits, and timing of a third dose of COVID-19 vaccine in accordance with provincial guidance.

Physician / Nurse Practitioner / Specialist Name: _______________________

College #: ________________ Signature: _____________________