REFERRAL FOR BCG VACCINATION

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

Mother's Name: _____

Address: _____

Phone: _____ Mobile: _____

GP: _____

Baby's Name: _____ Date of birth: _____

NHI: _____ Ethnicity: _____

Communication/language needs: _____

Date of travel if applicable: _____ Email: _____

Eligibility Assessment

Neonatal BCG should be offered to infants at increased risk of tuberculosis, defined as those who:

	YES	NO
Will be living in a house or family with a person with current or past tuberculosis	☐	☐
Have parents or household members who, in the past 5 years, have lived at least 6 months in a country with high incidence of tuberculosis *	☐	☐
During their first 5 years, will be living at least 3 months in a high Incidence country *	☐	☐

** High-incidence countries (> 40 cases per 100,000 population) include most of Africa, Asia, Middle East and parts of Eastern Europe (including Russia) and South America. Pacific countries include PNG, Solomon Islands, Fiji and Vanuatu, but not Samoa and Tonga. More information is available at: https://www.healthed.govt.nz/resource/bcg-vaccine-information-health-professionals.*

If one or more of the boxes are marked YES, then BCG vaccination is recommended for this baby and this form should be faxed/emailed to the Public Health Nursing Service.

If all boxes are marked NO this baby is not eligible for a BCG vaccination.

Form completed by: _____ Service Provider or Practice: _____
(Midwife or other Health professional)

Contact Phone: _____ Date: _____

Please fax/email to Public Health Nurse:

Community Health 4 Kids

Tauranga
Phone: 07 577 3383
Fax: 07 578 5485

Freephone: 0800 935 554

Whakatane
Phone: 07 306 0944
Fax: 07 306 0987

PRINT FORM | EMAIL to PHN.Referral@bopdhb.govt.nz | CLEAR FORM