HNE Kids Immunisation Referral Form

Send completed form to RIMS fax **49 22 3904**

PATIENT DETAILS			
Name		Date of Birth	
MRN or Address			
Contact Number			
Cultural Identity	☐ Aboriginal ☐ Torres Strait Islander ☐ Other:		
REFERRAL			
Referral for:	☐ Nurse-led immunisation ☐ Advice for an Adverse Event Following Immunisation (AEFI)- specify below Specialist immunisation medical consultation: ☐ High-risk condition- specify below ☐ Catch-up vaccination plan ☐ Vaccine hesitancy:		
The following vaccine(s) are requested:			
MEDICAL HISTORY			
Please list any relevant medical history:			
Please detail any known adverse events following immunisation (AEFI):			
Has AEFI been reported to the TGA and the local Public Health Unit?	☐ Yes ☐ No:		
REFERRER DETAILS			
Name:		Provider Number:	
Referring service:			
Address:			
Signature:		Date:	