

**MINISTRY OF HEALTH (MOH) – REFERRAL FORM FOR IN-SITU PAEDIATRIC VACCINATION (COVID-19)**

<b>PART 1: REFERRAL TO PAEDIATRIC VACCINATION CLINIC AT NATIONAL UNIVERSITY HOSPITAL (NUH) DOCTOR TO COMPLETE</b>	
<b>PATIENT INFORMATION (TO AFFIX PATIENT STICKER IF AVAILABLE)</b>	
Full Name (as per BC/NRIC/FIN)	
BC/NRIC/FIN No.	Nationality:
Date of Birth (DOB) & Gender	DOB: [in DD-MM-YYYY] <input type="checkbox"/> Male <input type="checkbox"/> Female
Residential/Mailing Address	
Name of Parent/Legal Guardian	
Parent's/Legal Guardian's Handphone No.	
<b>ALLERGY INFORMATION</b>	
ALLERGY/ANAPHYLAXIS TO VACCINES, OR DRUGS	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please specify: _____ <i>Note: Vaccine or Drug allergy is not a contraindication to receiving the Pfizer mRNA vaccine. Referral is not required for this, and patient can be vaccinated in the community VC.</i>
ALLERGY TO POLYETHYLENE GLYCOL (PEG)	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>Note: PEG allergy is a contraindication for the Pfizer mRNA vaccine. Do not vaccinate. Referral is not required.</i>
<b>REASONS FOR REFERRAL TO HOSPITAL FOR VACCINATION</b>	
Persistent fluid overload or pulmonary hypertension, and/or NYHA class 3 or 4 symptoms	<input type="checkbox"/> No <input type="checkbox"/> Yes Medications (if any):
Severe, symptomatic stenotic valvular heart disease (with angina, faints, shortness of breath)	<input type="checkbox"/> No <input type="checkbox"/> Yes Medications (if any):
Hypertrophic cardiomyopathy with outflow tract obstruction	<input type="checkbox"/> No <input type="checkbox"/> Yes Medications (if any):
Advanced neuromuscular conditions with chronic respiratory failure, especially those on prolonged BiPAP support	<input type="checkbox"/> No <input type="checkbox"/> Yes Medications (if any):
Chronic lung disease with need for respiratory support (i.e. on supplemental oxygen or requiring suctioning)	<input type="checkbox"/> No <input type="checkbox"/> Yes Medications (if any):
Other non-medical reasons <i>(these will be subject to review by the hospital vaccination team and assessed on a case-by-case basis)</i>	Please specify clearly:
<b>Need for respiratory support (e.g. BIPAP, CPAP, tracheostomy etc)</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, please specify: _____	
<b>Conditions requiring isolation or infection control measures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, please specify: _____ (e.g. MRSA, VRE, CRE colonized etc)	

**Additional Information Regarding the Patient's Condition:****Referred by:** \_\_\_\_\_Name & MCR No. (stamp), Signature  
& Date\_\_\_\_\_  
Clinic/Hospital/Vaccination Centre  
& Contact No.**INSTRUCTIONS TO PARENT/ LEGAL GUARDIAN**

- Your child/ ward has been referred for mRNA COVID-19 vaccination in the hospital. This service is free and the hospital will contact you with more details.
- An SMS notification for confirmation of your child's/ ward's appointment with the vaccination clinic should be sent to you by NUH within three to five (3 to 5) working days from the date of successful referral. If you have not received the SMS notification, please contact the Vaccination Site to enquire.
- Upon receiving the confirmation of your child's/ ward's appointment, should you have any further queries related to the status of your child's/ ward's referral for vaccination, please contact NUH.
- Your child/ ward will receive the first dose of the mRNA COVID-19 vaccination on the scheduled appointment date and a date for the second dose of the vaccine will be scheduled after the first dose has been completed.

**Details of the Paediatric Vaccination Clinic:**

<b>National University Hospital (NUH)</b>	<b>Things to Note for Your child's/ward's SOC Visit</b>
Viva-University Children's Cancer Centre (VUC3) NUH Medical Centre, Zone B Level 9 Contact number: 6772 5030 Email: vuc3@nuhs.edu.sg Operating hours: 8:00am to 5:30pm (Mon-Fri), 8:00am to 12:00pm (Sat)	Please arrive <u>10-20 mins</u> before your child/ward's appointment time and bring along the following items: <ul style="list-style-type: none"><li>• BC/NRIC/FIN/ ID or Passport of your child/ward</li><li>• Completed Referral Form – <i>this document</i></li><li>• [If any] Medical records / document related to your child/ward's medical condition</li></ul>

**NOTES FOR REFERRING DOCTORS**

- Patients deemed unsuitable for vaccination in the community setting should be deferred before a referral is made for in-situ vaccination in a hospital setting
- You may refer to the "**Operations Instruction to Vaccination Providers for the Conduct of COVID-19 Moderna Vaccination For Children Aged 6 Months To 4 Years, Section: Clinical Guidance, Administration of Vaccine to Children Aged 6 Months to 4 Years**" for more details