

## REFERRAL FOR BCG VACCINATION

|                                     |                            |
|-------------------------------------|----------------------------|
| Mother's Name: _____                |                            |
| Address: _____                      |                            |
| Phone: _____                        | GP: _____                  |
| Email: _____                        |                            |
| Baby's Name: _____                  | Date of birth: _____       |
| NHI: _____                          | Ethnicity: _____           |
| Communication/language needs: _____ |                            |
| Date of travel if applicable: _____ | Guthrie test result: _____ |

### 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   | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 * | <input type="checkbox"/> | <input type="checkbox"/> |
| During their first 5 years, will be living at least 3 months in a high Incidence country *  | <input type="checkbox"/> | <input type="checkbox"/> |

\* 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  
 (Midwife or other Health professional) or Practice: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Date: \_\_\_\_\_

**Please email to Public Health Nurse:**

#### Community Health 4 Kids

Tauranga

Phone: 07 577 3383

Freephone: 0800 935 554

Email: PHN.referral@bopdhb.govt.nz

Whakatane

Phone: 07 306 0944

**PRINT FORM**

**EMAIL to Public Health Nurse (PHN) Service**

**CLEAR FORM**