

**PRESCRIBER'S ORDER SHEET**

**Long Term Care  
COVID-19 Vaccine**

**ADULTS ONLY (18 years of age and older)**

<input type="checkbox"/> Indicates "checked" unless specifically cancelled by prescriber.					
Drug Allergies <b>See LTC Allergy and Intolerance Record</b>	ORDER TRANSCRIBED AND ACTIVATED				
<div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> <b>R</b> </div> <div style="width: 50%; text-align: center;"> <b>MEDICATION ORDERS</b> TO BE INITIATED OR DISCONTINUED         </div> </div>	<div style="display: flex; justify-content: space-between;"> <div style="width: 40%; text-align: center;"> </div> <div style="width: 50%; text-align: center;"> <b>GENERAL ORDERS</b> </div> </div>				
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-bottom: 1px dashed black;">DATE</td> <td style="width: 50%; border-bottom: 1px dashed black;">TIME</td> </tr> <tr> <td style="font-size: small;">DAY/MONTH/YEAR</td> <td style="font-size: small;">24 HOUR CLOCK</td> </tr> </table> <p><b>Primary COVID-19 Vaccine Series:</b>  <i>Check the doses that are required</i></p> <p> <input type="checkbox"/> First dose  <input type="checkbox"/> Second dose  <input type="checkbox"/> Third dose (for adults with moderate or severe immune compromised only)     </p> <p>Comirnaty (Pfizer-BioNTech) COVID-19 mRNA vaccine 0.3 mL IM  <b>OR</b>      Spikevax (Moderna) COVID-19 mRNA vaccine 0.5 mL IM     </p> <p><b>COVID-19 Vaccine Booster Dose:</b>      Verify eligibility and correct interval between vaccine doses. Use a new order sheet for each vaccine booster dose.</p> <p><i>Check <u>one</u> based on vaccine availability, eligibility, or resident preference</i></p> <p> <input type="checkbox"/> Bivalent COVID-19 vaccine:      Spikevax Bivalent Original/Omicron BA.4/5 (Moderna) COVID-19 mRNA vaccine 0.5 mL IM x 1 dose  <b>OR</b>      Comirnaty Original &amp; Omicron BA.4/BA.5 (Pfizer-BioNTech) Bivalent COVID-19 mRNA vaccine 0.3 mL IM x 1 dose  <b>OR</b> </p> <p> <input type="checkbox"/> Alternate COVID-19 vaccine:      Comirnaty (Pfizer-BioNTech) COVID-19 mRNA vaccine 0.3 mL IM x 1 dose  <b>OR</b>      Spikevax (Moderna) COVID-19 mRNA vaccine 0.5 mL IM x 1 dose (for <u>first</u> booster for adults of any age living in a personal care home)  <b>OR</b>      Spikevax (Moderna) COVID-19 mRNA vaccine 0.25 mL IM x 1 dose (for <u>second</u> booster dose for all populations)     </p>	DATE	TIME	DAY/MONTH/YEAR	24 HOUR CLOCK	<ul style="list-style-type: none"> <li><input type="checkbox"/> The healthcare professional administering vaccine must verify consent from the resident or substitute decision maker and document on the Manitoba COVID-19 Vaccine Consent Form.</li> <li><input type="checkbox"/> The healthcare professional administering the vaccine will screen the resident for vaccine contraindications and document on the Manitoba COVID-19 Vaccine Consent Form.</li> <li><input type="checkbox"/> The healthcare professional administering vaccine must verify the vaccination status of the resident including the brand administered and date of previous doses of COVID-19 vaccine. The following sources can be used for confirming vaccination status: copy of the consent form with vaccination administration documentation, Public Health Information Management System (PHIMS), eChart, Shared Health Immunization Record, or Pan-Canadian Proof of Vaccination Credential (PVC).</li> </ul> <p><b>Monitoring</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Observe and monitor for signs and symptoms of anaphylaxis, syncope for 15 minutes following vaccine administration.</li> <li><input type="checkbox"/> Observe and monitor for signs and symptoms of anaphylaxis, syncope for 30 minutes following vaccine administration in residents with a history of allergic reaction to other vaccines, medicines, food or other substances.</li> <li><input type="checkbox"/> Refer to the management of anaphylaxis on the PCH Medication Standing Orders (Aug 2021) and in the WRHA LTC Management of Suspected Anaphylaxis in LTC/PCH Residents Operational Guideline (Sep 2021)</li> </ul>
DATE	TIME				
DAY/MONTH/YEAR	24 HOUR CLOCK				
PRESCRIBER'S SIGNATURE _____  PRINTED NAME _____	TRANScribed: _____ REVIEWER: _____				
GENERIC EQUIVALENT AUTHORIZED					