uOttawa

Clinical Placement Risk Management

Hepatitis B Second Immunization Series and Serology Follow-up

Program

Medicine ❒	Medicine ❒	Pharmacy ❒
❑ Undergraduate ❑ Undergraduate Elective □ Visiting Medical Student □ Canadian Studying Abroad □ International	❑ Postgraduate ❑ Postgraduate Elective ❑ Enhancement Year Program	❑ Undergraduate

Last name:_____ **First name:**_____

Student number:_____ **Year of admission:**_____

Email:_____ **Telephone:**_____

Date of birth (yyyy/mm/dd):_____/ _____/_____

Primary Documentation

Initial vaccination series: ❑ None on file

Dose 1: (yyyy-mm-dd)____/____/____ Dose 2: (yyyy-mm-dd)____/____/____ If applicable, Dose 3: (yyyy-mm-dd)____/____/____

Serology (blood work):

Negative hepatitis B surface antibody (Anti-HBs) result: Date (yyyy-mm-dd)____/____/____

Negative hepatitis B surface antigen (HBsAg) result: Date (yyyy-mm-dd)____/____/____

FOLLOW-UP

To be completed by the Health Care Provider

If identified as non-immune (<than 10IU/L) and HBsAg is negative, please provide the following:

Obtain and provide date of **first booster vaccine:** Date (yyyy-mm-dd):____/____/____

Provide date and result of Anti-HBs **blood test (attach lab report). BLOOD TEST MUST BE DONE 30 DAYS AFTER FIRST BOOSTER VACCINE, NO EARLIER.** Anti-HBs: Date (yyyy-mm-dd):____/____/____ Result:_____IU/ml If ≥than 10IU/L **no further action.**

If <than 10IU/L **proceed to second (2nd) and third (3rd) booster vaccines:**

Obtain and provide date of **second booster vaccine:** Date (yyyy-mm-dd):____/____/____**MUST BE DONE 1 MONTH (MINIMUM OF 28 DAYS) FROM THE FIRST BOOSTER.**

Obtain and provide date of **third booster vaccine:** Date (yyyy-mm-dd):____/____/____**MUST BE DONE 5 MONTHS AFTER THE SECOND BOOSTER VACCINE.**

Provide date and result of Anti-HBs **blood test (attach lab report). BLOOD TEST MUST BE DONE 30 DAYS AFTER COMPLETING SERIES, NO EARLIER.** Anti-HBs: Date (yyyy-mm-dd):____/____/____ Result:_____IU/ml If ≥than 10IU/L **no further action.**

If <than 10IU/L **no further vaccination.**

Attesting Signature of Health Care Professional (HCP)

Name:_____

Signature:_____

Title:_____

Date (yyyy/mm/dd):_____/_____/_____

Stamp:

Please email this form to your corresponding Clinical Placement Risk Management Advisor at the University of Ottawa.