



uOttawa

Clinical Placement Risk Management

Hepatitis B Second Immunization Series and Serology Follow-up

Program		
Medicine <input type="checkbox"/> <input type="checkbox"/> Undergraduate <input type="checkbox"/> Undergraduate Elective <input type="checkbox"/> Visiting Medical Student <input type="checkbox"/> Canadian Studying Abroad <input type="checkbox"/> International	Medicine <input type="checkbox"/> <input type="checkbox"/> Postgraduate <input type="checkbox"/> Postgraduate Elective <input type="checkbox"/> Enhancement Year Program	Pharmacy <input type="checkbox"/> <input type="checkbox"/> 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: _____
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Please email this form to your corresponding Clinical Placement Risk Management Advisor at the University of Ottawa.