

TDAP SPECIAL PROJECT

VACCINE ORDER FORM

OREGON IMMUNIZATION PROGRAM – PUBLIC HEALTH DIVISION

| Date: | Provider ID #: | | County: | | |
|--|----------------|--|---------|--|--|
| Name of Agency: | | | | | |
| Address for Delivery (No. P.O. Boxes): | | | | | |
| City | | | ZIP | | |

| Vaccine | Doses Needed In Vials | Doses Neede In Syringes | d Brand Name | Age Range |
|---------------------------------------|--------------------------|----------------------------|-----------------------------|-----------------------|
| Tdap | | | Boostrix® | 11-18 years |
| Tdap | | | Adacel® | 11-64 years |
| Delivery days (circle all | that apply): M T | W TH F | Delivery Hours: () | <u>AM</u> - <u>PM</u> |
| PRINT NAME of Person Completing Order | | | Telephone | |

Email of Person Completing Order: _____

By printing name, I certify that my refrigerator & freezer temperatures are within the recommended range to store vaccines (range on back).

Vaccine is purchased from multiple funding sources, including federal funds under CFDA #93.268 – the Immunization and VFC Grants

Visit our website at <u>http://www.oregon.gov/DHS/ph/imm/adults/Tdap.shtml</u> To request this material in an alternate format (e.g. Braille), please call (971)673-0300.

| *************************************** | | | | | | | | |
|---|-----------------|-----------------|------------|---------------|--|--|--|--|
| This section for DHS Use Only | | | | | | | | |
| Vaccine | Lot Number/ | Lot Number/ | Brand Name | Doses on Back | | | | |
| | Doses Shipped - | Doses Shipped - | | Order | | | | |
| | VL | SYR | | | | | | |
| | | | | | | | | |
| Tdap | | | Boostrix® | | | | | |
| | | | | | | | | |
| Tdan | | | Adaaal® | | | | | |
| Tdap | | | Adacel® | | | | | |
| | | | | | | | | |

Date Of Shipment: _____

INSTRUCTIONS FOR FILLING OUT THE SPECIAL PROJECT TDAP VACCINE ORDER FORM

PIN. Use Provider Identification Number (PIN) on all orders - Assigned by the Immunization Program.

Doses Requested - Enter number of vaccine doses needed for eligible populations in one of these two columns. With some brands, you have a choice of vials or syringes, please specify your **doses requested** in the appropriate column. Doses shipped will be adjusted to conform to the available package size. Please allow 10-14 business days for delivery, after receipt at the Oregon Immunization Program.

Delivery Instructions – Providers <u>must</u> indicate days/clinic hours when vaccine may be delivered. Delivery instructions must be indicated **each time an order is placed**. Please note clinic days/hours due to holidays or special events. Do not make requests of courier (i.e., "tell staff to put in fridge" or "take 2^{nd} left after light," etc.). Orders cannot be "left at door." All order requests must be signed.

Fax to Oregon Immunization Program. Retain a copy for your records. Please fax your vaccine order to the number below. Phone orders will be accepted only in emergency cases.

OREGON IMMUNIZATION PROGRAM, PUBLIC HEALTH DIVISION www.oregon.gov/dhs/ph/imm 971-673-0300 FAX: 971-673-0278

Acceptable temperature ranges for vaccine storage:

Refrigerator: 2° to 8°C (35° to 46°F) Freezer: -15°C (5°F) or colder