**HIGH RISK OF VACCINE REACTION REFERRAL FORM TO**

**QUINTE HEALTH CARE**

**Please Fax to 613-902-5861 OR email to vacclinic@qhc.on.ca**

Name of Person referring:

Contact Number of MD/Office:

Name of Client:

Health Card Number:

Month:

Day:

Date of Birth:

Year:

Phone Number:

Reason for ‘High Risk’ Status:

***COVID ASSESSMENT CALL CENTRE – PLEASE FORWARD COMPLETED FORM TO OCCUPATIONAL HEALTH FOR REVIEW***