# Rhode Island Department of Health
# Monthly Vaccine Order Form

1. Fax your order at least 4 business days before pick-up to 401-222-3805.
2. All orders should to be no less than a 30-day supply and no more than a 60-day supply.
3. Please do not fax to the hospital pharmacies. This is done by DOH after approval. DOH will fax the approved Vaccine Order Form back to you.
4. When picking up vaccine, please bring your approved Vaccine Order Form, a cooler, and ID.

Practice Name: _____ Ordering Physician: _____

Contact: _____ Telephone: _____ FAX: _____

Date of Order: _____ Pick-up site: _____

Refrigerator Temperature(s): _____Freezer Temperature(s): _____

| Vaccine | Number of Doses On-hand | Number of Doses Requested | Number of Doses Approved (DOH use only) | DOH Comments | Number of VIS* Requested |
|---|---|---|---|---|---|
| DTaP-Hep B-IPV Pediarix | DOSES | DOSES | DOSES | | |
| Hib PedVax Hib (3 dose series) | DOSES | DOSES | DOSES | | |
| Pneumococcal Conjugate Prevnar | DOSES | DOSES | DOSES | | |
| IPV | DOSES | DOSES | DOSES | | |
| DTaP | DOSES | DOSES | DOSES | | |
| MMR | DOSES | DOSES | DOSES | | |
| Hepatitis B | DOSES | DOSES | DOSES | | |
| DT (< 7 years) | DOSES | DOSES | DOSES | | |
| Td (7-18 years) | DOSES | DOSES | DOSES | | |
| Meningococcal Conjugate Menactra (MCV4) (11-18 years) | DOSES | DOSES | DOSES | | |
| Meningococcal Polysaccharide Menomune (MPSV4) (2 -10 years – high-risk) | DOSES | DOSES | DOSES | | |
| Hepatitis A (2-18 years – high-risk) | DOSES | DOSES | DOSES | | |
| Pneumococcal Polysaccharide (2-18 years – high-risk) | DOSES | DOSES | DOSES | | |
| Hepatitis B (Adult) ** | DOSES | DOSES | DOSES | | |
| Hepatitis A (Adult) ** | DOSES | DOSES | DOSES | | |
| PPD 1mL/5mL | DOSES | DOSES | DOSES | | |

* Vaccine Information Statements ** Adult vaccines by pre-arrangement only.

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