

# TDAP EXPANSION PROJECT 2010

**VACCINE ORDER FORM** FAX TO: **877-329-9832**

**Please complete all sections of this order form**

NAME OF CLINIC <input style="width:95%;" type="text"/>		DATE <input style="width:95%;" type="text"/>	PIN NUMBER (6 DIGIT) <input style="width:95%;" type="text"/>
DELIVERY ADDRESS <input style="width:95%;" type="text"/>		ZIP <input style="width:95%;" type="text"/>	CITY <input style="width:95%;" type="text"/>
PHONE <input style="width:95%;" type="text"/>		EMAIL <input style="width:95%;" type="text"/>	
FAX <input style="width:95%;" type="text"/>		COUNTY <input style="width:95%;" type="text"/>	
<input type="checkbox"/> <b>Check Box if NEW ADDRESS.</b>			
CONTACT NAME <input style="width:95%;" type="text"/>			
Hours when vaccine can be received (if closed, leave hrs blank)			
Tue	From: <input style="width:20px;" type="text"/>	to: <input style="width:20px;" type="text"/>	(Closed for lunch from <input style="width:20px;" type="text"/> to: <input style="width:20px;" type="text"/> )
Wed	From: <input style="width:20px;" type="text"/>	to: <input style="width:20px;" type="text"/>	(Closed for lunch from <input style="width:20px;" type="text"/> to: <input style="width:20px;" type="text"/> )
Thur	From: <input style="width:20px;" type="text"/>	to: <input style="width:20px;" type="text"/>	(Closed for lunch from <input style="width:20px;" type="text"/> to: <input style="width:20px;" type="text"/> )
Fri	From: <input style="width:20px;" type="text"/>	to: <input style="width:20px;" type="text"/>	(Closed for lunch from <input style="width:20px;" type="text"/> to: <input style="width:20px;" type="text"/> )

Tdap Vaccines	DOSES USED	VACCINE INVENTORY (DOSES ON HAND)		NEW VACCINE ORDER		
	Number of doses used since last order. Enter "0" if none.	Number of doses on hand (current inventory). Enter "0" if none.	Lot Number(s)	Brandname	Doses Requested (Multiples of 10, Enter "0" if none)	Formulation (Check preferred)
Post-partum	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>		Adacel®	<input style="width:40px;" type="text"/>	<input type="checkbox"/> Single dose vials-10 per box
Household contacts	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>				<input type="checkbox"/> Single dose syringes-5 per box
Total	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:100px;" type="text"/>			
Post-partum	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>		Boostrix®	<input style="width:40px;" type="text"/>	<input type="checkbox"/> Single dose vials-10 per box
Household contacts	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>				<input type="checkbox"/> Single dose syringes-5 per box
Total	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:100px;" type="text"/>			

IF MY VACCINE BRAND CHOICE AND PACKAGING IS NOT AVAILABLE:

- Send a substitute brand/packaging
- Send only the brand/packaging I requested when available

FAX the completed Vaccine Order Form  
to: **877-329-9832**