**Request for BCG Vaccination**

Babies under 12 months born in Mid Yorkshire Trust should be referred back to Mid Yorkshire Maternity Services where they will receive the BCG vaccination.

The contact number is- **01924 512178.**

Children who move into the catchment area for Mid Yorkshire NHS Trust CCG under 12 months of age who are identified as eligible for BCG vaccine and who have not yet received their vaccination will need a direct referral from the GP / HV to the specialist TB nursing team to be vaccinated. Community TB service contact number**-03033309869**

**They do not require a referral to the Mid Yorkshire Paediatric Outpatient BCG clinics.**

Please follow the flow chart overleaf before completing the request for BCG vaccination. If incomplete forms are submitted, they will be returned to the referrer to be completed fully.

Name of Child ....................................................DOB................................NHS Number...........................................

Address .................................................................................... Telephone ................................................

................................................................................................. ................................................................

............................................................................................... Place of Birth............................................

(Name and Address of Hospital)

Mothers Name...................................................................... Mothers NHS No.....................................

Confirmed parents wish BCG Vaccination to be requested (please tick if confirmed)

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Text Box Tools tab to change the formatting of the pull quote text box.]

**Criteria for BCG Vaccination** (please tick)

1. The child was born in a country where the annual incidence of Tuberculosis (TB) is 40/100,000 population or greater. Name of Country .....................................................................................................................
2. The child’s Parent or Grandparent was born in a country where the annual incidence of TB is 40/100,000 population or greater. Name of Country......................................................................................................
3. Confirmed family history of TB in the past 5 years. Name of person who had TB/Year/Address...................

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**Checklist**

Launch SCID result if applicable

Check mother was not treated with any

immunosuppressant during pregnancy

Checked system 1 and no record of BCG given

Check parent held record and no record of BCG seen

Checked child for BCG scar and scar not seen

Details of any pre-existing medical conditions and treatment

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Name and location of any Consultant involved in care of child.....................................................................................

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No HIV risk identified from birth records or child’s records date checked............

(e.g., Maternal HIV status negative) Please tick and date to indicate no risk identified)

Name and designation of person legally able to provide consent..............................................Mother/Father/Other

If this is not the parent then please provide the name /address/designation of the person with legal parental responsibility for child. Please remember if the child is a looked after child with shared parental responsibility with parent and Local authority and natural mothers’ consent is being overridden in the best interest of the child this should be stated and a copy of the legal order sent with the referral.

Statement of why parental consent is being overridden

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.........................................................................................

Signature

Name.........................................................................

Designation.................................................................

Address......................................................................

....................................................................................

....................................................................................

Telephone .................................................................

Name of Referrer........................................................Designation ..........................................................

Contact Telephone ......................................................Signature .........................................................

**CHECK FLOW CHART**

Not Eligible for BCG Vaccination

N0

Is the child Under 16 years of age?

N

Yes

Not eligible for further BCG vaccination.

Record vaccination/or evidence of scar seen on systm1 if not already recorded.

Has the child had BCG vaccination previously?

* Check systm1 record.
* Check parent held record.
* Check child for evidence of BCG scar.

YES

NO

3

Has there been a confirmed case of TB within the family in the past 5 years?

(details please)

2

Was the child’s parent or grandparent born country with an annual TB incidence of 40 cases per 100,000 population

or greater. please see

**Website: www.gov.uk/phe**

for current TB rates by country.

1

Was the child born in a country or lived in a country for a prolonged period of 3 months or more (with an annual TB incidence of 40 cases per 100,000 population or greater.

please see

**Website: www.gov.uk/phe**

YES to 1. 2. or 3 above. NO

Child not eligible under routine BCG programme. If vaccination required for travel/ occupational exposure patients should be directed to travel clinics. If other requests outside these raised, please contact TB service.

Child fits Criteria for BCG VACCINATION

Before completing referral please follow next steps.

Are the parents in agreement for BCG vaccination? Please do not refer unless you have confirmed the parent wishes BCG to be given.

Does the child have any pre-existing medical conditions?

Details needed.

Is the child under the care of a consultant?

\*Details needed.

Is there an HIV infection risk for the child?

Please note if parent HIV status is known to be positive or the child has a known HIV risk then the child must be

referred to a GP or paediatrician for 2 appropriately timed HIV blood tests **before** referring for BCG vaccination.

You will need the name of the person legally able to provide consent and further details will be needed if the child is a looked after child with shared parental responsibility between natural parents and the Local Authority. All attempts to gain consent of natural parents who retain parental responsibility should be made. I f this consent cannot be obtained then the local authority officer with parental responsibility may override the natural parent s consent in the best interests of the child. This will need to be stated on the referral and a copy of the legal order attached.

**PLEASE FULLY COMPLETE THE REFERRAL FORM AND FORWARD EMAIL TO**

[**LCP.kirkleestbservice@locala-cic.nhs.uk**](mailto:LCP.kirkleestbservice@nhs.net)