Sid's Pharmacy

Influenza PROPHYLAXIS Questionnaire and Evaluation

_____ _____

First Name M.I. Last Name ☐ Male or ☐ Female Date of Birth (DOB)

_____ _____

Full Street Address (PO Box acceptable if given with physical address) Phone

Allergies: ☐ No Known Allergies ☐ Penicillin ☐ Sulfa ☐ Latex ☐ NSAIDS (Ibuprofen, naproxen, etc) ☐ Tamiflu (oseltamivir) ☐ Other: _____

Medical Conditions: ☐ No Known Medical Conditions ☐ High Blood Pressure ☐ Diabetes ☐ High Cholesterol ☐ Asthma ☐ Arthritis ☐ Depression ☐ Anxiety ☐ Immunocompromised ☐ Migraines ☐ Chronic Pain ☐ Acid Reflux ☐ Heart Failure or Coronary Artery Disease ☐ HIV ☐ Other:_____

PLEASE COMPLETE THE FOLLOWING SCREENING QUESTIONNAIRE TO THE BEST OF YOUR KNOWLEDGE. IF YOU HAVE ANY QUESTIONS, PLEASE ASK THE PHARMACIST.

		(Circle Your Answer)	
1	Are you experiencing ANY flu-like symptoms (fever, cough, sore throat, nasal congestion, muscle/body aches)	Yes	No
2	Are you UNDER the age of 6?	Yes	No
3	Is there a chance you could be pregnant?	Yes	No
4	If you have ever taken Tamiflu or Relenza, did you have any type of adverse reaction?	Yes	No
5	Have you had antiviral therapy in the last *4 weeks*?	Yes	No
6	Do you have a history of renal dysfunction?	Yes	No
7	Are you immunocompromised by a medication or condition?	Yes	No
8	Do you have any of the following conditions?: ● Asthma or any chronic pulmonary disease ● Diabetes ● Congestive heart failure or coronary artery disease ● HIV ● Sickle cell anemia or other inherited blood disorders ● Chronic renal dysfunction ● Cancer ● Neuromuscular, seizure, or cognitive dysfunction	Yes	No
9	Have you had an influenza vaccine this year?	Yes	No
10	If you have ever taken Tamiflu or Relenza, did you have any type of adverse reaction?	Yes	No

_____ _____

Signature Date

---------- *Pharmacy Use Below This Point* ----------

BP:_____ HR: _____ Breath Rate: _____ Oxygen:_____ Temp:_____

1. Are all *INCLUSION* Criteria met?
    - The patient is **over 6 years of age** **Yes** **No**
    - Meets ONE of the following criteria **Yes** **No**
        - Answers YES to any **Items 6-8**
        - Is **OVER 65 yo** or older
        - Has **NOT** been vaccinated against flu

2. Does the patient meet any *EXCLUSION* Criteria?
    - Circled "YES" on any **Items 1 - 5** **Yes** **No**

If the patient has ANY reason for exclusion, they should be referred to a primary care provider for further evaluation. Treating a patient that does not meet the stated criteria is not within the pharmacist's legal authority.

Patient Name_____ DOB _____

The following is the final recommendation and prescription of the pharmacist based on their clinical experience, knowledge, and evaluation of the patient.

Tamiflu Dosing:

Adult and Children >40kg

75 mg QD x10days

Children

(<23kg) 30 mg QD x 10 days (24-40kg) - 60 mg QD x 10 days

☐ **Tamiflu (oseltamivir) 75 mg tablets**

☐ Tamiflu (oseltamivir) 30 mg tablets

#10 Tablets

Sig: 1 tablet po QD x 10 days

☐ **Tamiflu (oseltamivir) 6 mg/ml suspension**

_____ mls (60 ml containers)

Sig: _____mls po QD for 10 days

☐ Relenza (zanamivir) inhaler (must be over 5yo)

#1 inhaler

Sig: Inhale 2 puffs po QD x 10 days ICD10: Z20.828

_____ _____

Pharmacist Signature Date