Sid's Pharmacy

Influenza TREATMENT 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 ☐ 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	Please check the symptoms that you have been experiencing: ☐ Fever ☐ Cough ☐ Sore Throat ☐ Nasal Congestion ☐ Muscle or Body Aches		
2	Have you been experiencing these symptoms for GREATER THAN 48 hours?	Yes	No
3	Are you UNDER the age of 6?	Yes	No
4	Is there a chance you could be pregnant?	Yes	No
5	Are you immunocompromised by a medication or condition?	Yes	No
6	Have you had antiviral therapy in the last *4 weeks*?	Yes	No
7	Do you have a history of renal dysfunction?	Yes	No
8	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**
   - They are exhibiting signs and symptoms of flu for **< 48hours** **Yes** **No**
   - **Positive** to the CLIA-waived influenza test **Yes** **No**

2. Does the patient meet any *EXCLUSION* Criteria?
   - Circled "YES" on any **Items 2 - 8** **Yes** **No**
   - Systolic Blood Pressure <100mgHg **Yes** **No**
   - Breath rate >25 breaths/min **Yes** **No**
   - HR >100 beats/min **Yes** **No**
   - Oxygenation <90% **Yes** **No**
   - Temperature >103°F **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 BID x5days

Children

(<15kg) 30 mg BID x 5 days (15-23kg) - 45 mg BID x 5 days (24-40kg) - 60 mg BID x 5 days

☐ **Tamiflu (oseltamivir) 75 mg tablets**
☐ Tamiflu (oseltamivir) 45 mg tablets
☐ Tamiflu (oseltamivir) 30 mg tablets
#10 Tablets
Sig: 1 tablet po BID x 5 days

☐ **Tamiflu (oseltamivir) 6 mg/ml suspension**
_____ mls (60 ml containers)
Sig: _____mls po BID for 5 days

☐ Relenza (zanamivir) inhaler (must be over 7yo)
#1 inhaler
Sig: Inhale 2 puffs po BID x 5 days ICD10: J11.1

_____ _____
Pharmacist Signature Date