Screening Form Template

For Patient to Complete

Name____________________________ Date of Birth _____________ Age______

Address __________________________ City __________________________

Zip_____________ Phone Number __________________________ Gender □ M □ F

Weight ________ lbs        Food or Medication Allergies ___________________________

Current Medications _______________________________________________________

________________________________________________________________________

Please Circle Yes or No for each question:

Are you pregnant or breastfeeding?  Y / N

Have you ever had an adverse reaction to medications to treat the flu before?   Y   /   N
Medications include Tamiflu® (oseltamivir), Relenza® (zanamivir), amantadine or rimantadine

Do you have a lung disease or breathing problem such as asthma or COPD (emphysema)?  Y   /   N

Has your doctor ever told you that your kidney function is decreased?  Y   /   N

Have you had a vaccine in the last month?   Y   /   N

Signature of Patient __________________________________ Date _____________

Or Signature of Parent or Guardian ___________________________ Date ___________

************************************************************************

PHARMACY: Please attach the prescription check label here:
For the pharmacist to complete

Please note the patient’s symptoms

Fever: □ Measured or □ Patient report  Temp __________ F / C

Please check the symptoms present: □ Cough □ Respiratory congestion □ Sore throat □ Wheezing □ Rhinorrhea □ Mild muscle aches □ Myalgia or arthralgia □ Cyanosis or impaired oxygen delivery □ Shortness of breath □ Gastrointestinal symptoms □ Other: ____________________________

Document patient factor that indicate high risk: □ Age <2 or >65yrs □ Immunosuppression □ Pregnant □ Chronic Diseases (see protocol) ____________________________ □ Chronic ASA therapy □ Nursing Home □ Other

When did the symptoms begin to occur? ________ Are the patient’s symptoms improving? □ Y □ N

Has the patient had close contact with someone exhibiting signs and symptoms of influenza? □ Y □ N

Is prescribing antivirals indicated? □ Y □ N  If Yes, is the Rx for □ Treatment □ Prophylaxis

If no, was counseling for follow up and worsening symptoms given? □ Yes □ No

************************************************************************************

Medication dispensed

Medication, dose and duration prescribed and dispensed:

□ Tamiflu®  Dose: □ 30mg □ 45mg □ 60mg □ 75mg □ other ________

  SIG: PO □ Qday □ BID □ other ________  Duration: □ 5 days □ 10 days □ other ________

□ Relenza®  Dose: □ 10mg  SIG: inhale □ Qday □ BID Duration: □ 5 days □ 10 days □ other ________

□ Other: __________________________________________________________

Medication Lot #: ______________ Expiration date ______________ RX #: ______________

Any Referral Required?

Was the patient referred to a physician or emergency care? Y / N  If yes, please describe why __________________________________________________________

Date ______________ Pharmacist Name and Signature ______________________________________

*Pharmacy: keep this form for your records. Submit a copy to the local health department as directed.*

PHARMACY: Please stamp with your store specific mailing stamp here for pharmacy identification: