BCCDC Antiviral Medication Administration Form

BC Centre for Disease Control
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

PLEASE FAX THIS FORM TO VACCINE AND PHARMACY SERVICES WHEN AN ANTI-VIRAL MEDICATION HAS BEEN USED.

FAX: (604) 775-2716

PATIENT DEMOGRAPHICS

Surname:		**Address:**
Given Name (s):		
Middle Name(s):		
Personal Health Number (PHN):		
Other ID / Reference # :		

Date of Birth (yyyy / mm / dd)	**Sex**	**Weight**	**Allegies**	**Telephone**	**First Nations Nursing Station (if applicable)**
	☐ Male ☐ Female	______ lbs ______ kg		( )	

MEDICATION

Drug	Dosage	Quantity Dispensed	Date Given	Lot # / Expiry Date Given
Tamiflu 75 mg	75 mg bid x 5 days	10 capsules		
Tamiflu 45 mg	45 mg bid x 5 days	10 capsules		
Tamiflu 30 mg	30 mg bid x 5 days	10 capsules		
Relenza	2 x 5 mg blister inhalations, bid x 5 days	20 blistered doses		

PRESCRIBER's NAME	

Signature:	
Telephone:	
Date:	

Vaccine and Pharmacy Services
655 West 12th Avenue Fax
Vancouver, British Columbia
Canada V5Z 4R4

Tel 604 660 6000
Fax 604 775 2716
or 604 775 2718
www.bccdc.org

A research and teaching centre affiliated with UBC