

Clinical Evaluation Form for Dispensing Post-Exposure Therapy

Date: ___/___/___

Interviewers Name: _____

Demographic Information

Last Name: _____ First Name: _____ MI: _____

Home Address: _____

Work Address: _____

Phone: _____ (Hm) _____ (Wk) _____ (Cell)

Date of Birth: _____ Weight: _____ lbs Gender: M F

Screening for Possible Health Effects from Exposure

Recent Illness: Have you developed any of the following symptoms in the past week?

- | | | | | | |
|---------------------------|------------------------------|-----------------------------|------------------------|------------------------------|-----------------------------|
| Cough/shortness of breath | Yes <input type="checkbox"/> | No <input type="checkbox"/> | New skin lesions | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Fever | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Severe headaches | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Chills | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Muscle aches | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Vomiting | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Mouth or throat ulcers | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Diarrhea | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | |

Past Medical History

Do you have any of the following medical conditions?

Kidney Disease Yes No Liver Disease Yes No

Are you allergic to any Medications?

Yes No If yes, please list medications and type of allergic response:

List all medications you are currently taking, including over the counter medications:

Are you currently taking medicines in any of the following categories? If possible list the name of the medicine.

- Medicine for abnormal heart rhythm _____
- Anticonvulsants/antiseizure _____
- Blood thinners _____
- Oral contraceptives/birth control _____
- Theophylline _____
- Antacids _____

In addition to the above, list the names of all other medications you are currently taking, including over the counter medications: _____

Females Only:

Are you currently pregnant? Yes No
Are you breast-feeding? Yes No

ACKNOWLEDGEMENT

I have received medication in accordance with the recommendations of the Centers for Disease Control and Prevention and the Georgia Division of Public Health. I have received the information sheets about the disease and medication. The risk and benefit of the use of antibiotics to prevent disease has been explained to me.

Signature (Self or Guardian) (Date)

DISPENSING INFORMATION (Nurse, Physician, Pharmacist, Dentist)

- Ciprofloxacin 500 mg BID x 10 days or ____ mg PO x ____ days Rx #: _____ Lot # _____ Quantity _____
- Doxycycline 100 mg BID x 10 days or ____ mg PO x ____ days Rx #: _____ Lot # _____ Quantity _____
- Amoxicillin 250 mg BID x 10 days or ____ mg PO x ____ days Rx #: _____ Lot # _____ Quantity _____
- Penicillin VK 500 mg BID x 10 days or ____ mg PO x ____ days Rx #: _____ Lot # _____ Quantity _____

Dispensed By : _____ RN,MD
RPh DMD Date ____ / ____ / ____

Additional Information Given to Patient: Disease Info Drug Info Physician Referral Primary Provider Notice

Refill Information

- Ciprofloxacin 500 mg or ____ mg PO x ____ days Rx #: _____ Lot # _____ Quantity _____
- Doxycycline 100 mg or ____ mg PO x ____ days Rx #: _____ Lot # _____ Quantity _____
- Amoxicillin 250 mg or ____ mg PO x ____ days Rx #: _____ Lot # _____ Quantity _____
- Penicillin VK 500 mg or ____ mg PO x ____ days Rx #: _____ Lot # _____ Quantity _____

Dispensed By : _____ RN,MD
RPh DMD Date ____ / ____ / ____