

**Antiviral Dispensing Report Form**  
 NM Department of Health

**Fax Forms Weekly - Every WEDNESDAY**  
**To: (505) 827-1741; ATTN: NMSIIS Registry**

**INSTRUCTIONS:** Use this form each time you dispense antivirals for treatment or prophylaxis. If you have questions about completing this form contact the DOH Helpdesk at 1-800-280-1618, option 1, or e-mail DOH-helpdesk-main@state.nm.us. Put "antiviral dispensing report" in the subject line.

<b>Facility</b>	<b>Facility Name:</b>	
	<b>NMSIIS VFC Site:</b>	
	<b>Contact Name:</b>	
	<b>Phone Number:</b>	

<b>Patient</b>	<b>Medical Record #</b>	
	<b>Last Name</b>	
	<b>First Name</b>	
	<b>Date of Birth (mm/dd/yyyy)</b>	
	<b>Gender (M/F)</b>	
	<b>County of Residence</b>	
	<b>Antiviral Given* (T12, T30, T45, T60, T75, R5)</b>	
	<b>Lot Number</b>	
	<b>Date Given (mm/dd/yyyy)</b>	
	<b>Indicate whether Dispensed for Treatment (Tx) or Post-Exposure Prophylaxis (PEP)</b>	
	<b>Date of Illness Onset*** (mm/dd/yyyy)</b>	
	<b>Hospitalized (Yes or No)</b>	
	<b>High-Risk Group (specify using list below)</b>	
	<b>Health Care Provider (Yes or No)</b>	

\*T=Oseltamivir (Tamiflu);  
 R=Zanamivir (Relenza);  
 numbers refer to dose in mg,  
 e.g. T75 = Tamiflu 75 mg capsules;  
 for additional dosing instructions see:  
<http://www.cdc.gov/h1n1flu/recommendations.htm>

\*\*Write "unknown" if date of illness onset is unknown; leave blank for persons receiving post-exposure prophylaxis

**High-Risk Groups:**

- A. Age < 5 yrs
- B. Age > 64 yrs
- C. Chronic pulmonary disease
- D. Cardiovascular disease (except hypertension)
- E. Immunocompromised
- F. Hemoglobinopathy (e.g. sickle cell disease)
- G. Long-term aspirin therapy and age < 19 yrs
- H. Chronic renal disease
- I. Chronic metabolic disorder (including diabetes)
- J. Neuromuscular disorders
- K. Resident of nursing home or chronic-care facility
- L. Pregnant
- Z. None of the above

