Ohio Department of Health

Three-Page NAPH

Anthrax Prophylaxis Screening, Consent, and Declination

Today's date

Patient information: Fill out or Prefix the label

Last name	First name	MI	Gender
			☐ Male ☐ Female

Home address	Date of birth	Home phone
		( )

City	State	ZIP	Other phone/pager
			( )

Primary care physician	City	Phone
		( )

Drug Allergies: (Note: Examples. Section relates to specific dispensed meds!)

Are you allergic to ciprofloxacin or another quinolone antibiotic? ☐ Yes ☐ No

If yes, describe reaction

Are you allergic to doxycycline or tetracycline? ☐ Yes ☐ No

If yes, describe reaction

Have you had a serious reaction to any other antibiotic? ☐ Yes ☐ No

If yes, list medication and describe the reaction

Current Medication and Medical History: (Note: Examples. Section relates to specific dispensed meds!)

Are you currently taking seizure medications?	☐ No	☐ Yes	☐ Don't know
Are you currently taking theophylline?	☐ No	☐ Yes	☐ Don't know
Are you currently taking probenicid (Benemidg)?	☐ No	☐ Yes	☐ Don't know
Are you currently taking cyclosporine (Neoralg, Sandimmuneg)?	☐ No	☐ Yes	☐ Don't know
Are you currently taking warfarin (Coumading)?	☐ No	☐ Yes	☐ Don't know
Are you currently taking SucralfaCarafateg), colestipol (Colestidg), cholestyramine (Questran(R))	☐ No	☐ Yes	☐ Don't know
Are you currently taking antacids, calcium? or iron supplements?	☐ No	☐ Yes	☐ Don't know
Are you currently on dialysis or has your physician discussed the possibility of dialysis-with you?	☐ No	☐ Yes	☐ Don't know

Reproductive history — *for females only*

Date of last menstrual period			☐ Don't know
Are you currently pregnant?	☐ No	☐ Yes	☐ Don't know
Are you currently breastfeeding?	☐ No	☐ Yes	
Are you currently using any form of birth control?	☐ No	☐ Yes	
If yes, are you taking oral contraceptives?	☐ No	☐ Yes	

Symptoms present during past 1 week: (Note: Section relates to specific disease/exposure situation!)

Respiratory symptoms (cough/shortness of breath/chest pain)	☐ No	☐ Yes	☐ Don't know
Fever or chills	☐ No	☐ Yes	☐ Don't know
Muscle aches	☐ No	☐ Yes	☐ Don't know
Severe headache or stiff neck	☐ No	☐ Yes	☐ Don't know
New skin lesions (blisters, skin ulcers, black lesions)	☐ No	☐ Yes	☐ Don't know
Nausea /vomiting	☐ No	☐ Yes	☐ Don't know
Bloody diarrhea	☐ No	☐ Yes	☐ Don't know
Hospitalized in the past month for pneumonia, Meningitis, or unexplained infectious illness	☐ No	☐ Yes	☐ Don't know

For screener/dispenser use only

Patient disposition: (Example: Section relates to specific dispensed meds!)

Dispense Ciprofloxacin if no allergy to ciprofloxacin or other quinolones and no other contraindications.

Dispense Doxycycline if ciprofloxacin or other quinolones allergy and no Doxycycline or other tetracycline allergy or other contraindications.

If patient is allergic to both ciprofloxacin and doxycycline or answered 'Yes' to any contraindications, refer to medical evaluator *and do not sign this form.*

Screener / Dispenser

Signature	Credentials	Date

Medication Dispensed (check and fill in lot #)

Note: specific medications/dosage/frequency to be deten-nined specific to the situation—consistent with the Standing Orders—and included here.

Medication	Dose (mg)	Route	Frequency	Lot number

For medical evaluator use only

MD / PA / RN / NP / Pharmacist note (include pertinent medical history, current medications, and allergies)

Medication dispensed

☐ Checked above

☐ Other medication

Type, dose, route, frequency, lot number

☐ None

Explain

Referral

☐ To hospital

Name	Phone

☐ To physician

Name	Phone
Reason for referral	

Medical evaluator

Signature	Credentials	Date

Consent / declination for medication

☐ I have discussed the risks and benefits of the recommended medication with the _____ staff and I consent to the medication indicated above.

Individual or authorized person

Signature	Date

☐ I have discussed the risks and benefits of the recommended medication with the staff and I decline the recommended medication.

Individual or authorized person

Signature	Date
Witness	Date