PERTUSSIS SCREENING FORM

Patient Name: _____ Date: _____ Date of Birth: _____

☐ Inform patient of exposure ☐ Review chart

Is the patient newly symptomatic (congestion, runny nose, fever, cough) since the exposure?

☐ No ☐ Yes If yes, describe: whoop/paroxysmal/prolonged cough/post-tussive emesis/apnea/other: _____

☐ Note time of onset: _____

☐ Recommend medical evaluation/treatment

Was anyone with the patient in the exam room at the time of visit?

☐ No ☐ Yes If yes, name: _____

☐ Not our patient: Refer for preventive treatment.

☐ Our patient: Pull chart and schedule patient for treatment.

☐ Document in patient's chart

☐ Inform patient of treatment options.

Does patient have antibiotic allergies?

☐ No ☐ Yes If yes, list: _____

Select prophylactic treatment:

☐ Biaxin XL 500 mg: Two tablets by mouth every day for 14 days. Disp#28 Ref#0

☐ Erythromycin 500 mg: One tablet by mouth every 6 hours for 14 days. Disp#56 Ref#0

☐ Septra DS (TMP = 160 mg per tablet): One tablet by mouth twice daily for 14 days. Disp#28 Ref#0

☐ Zitrhomax Zpack: As directed for 5 days. Disp#1 Ref#0

Second-line therapy:

☐ Doxycycline 100 mg by mouth twice daily for 14 days. Disp#28 Ref#0

☐ Levaquin 500 mg: One tablet by mouth daily for 7 days. Disp#7 Ref#0

Pediatric dosing:

Weight = _____ kg

☐ Biaxin suspension: 15-20 mg/kg/day orally, in 2 divided doses for 7 days. (Maximum 1 g/day)

☐ Erythromycin estolate: 40-50 mg/kg/day orally, in 4 divided doses for 14 days. (Maximum 2g/day)

☐ Septra/Bactrim suspension: 8 mg/kg/day (based on TMP) orally, in two divided doses for 14 days.

☐ Zithromax suspension: 10-12 mg/kg/day orally, once daily for 5 days. (Maximum 600 mg/day)

Pediatrix Rx:

☐ Call pharmacy: _____

☐ Caution patient to be checked if symptoms develop.

☐ Answer patient's questions.

Caller signature _____

Physician signature _____ MD/CRNP

Family Practice Management®

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