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COMMUNITY PHARMACIST LIAISON FORM

Initiating single-dose doxycycline in an asymptomatic person with a tick bite that occurred in a PEP (post-exposure prophylaxis)-designated geographical area

No. 628012

PHARMACY (OR PHARMACIST) IDENTIFICATION

Collective prescription number (if applicable):

Institution:

PATIENT IDENTIFICATION

Last name:

First name:

Date of birth:

Health insurance number:

NAME:

TELEPHONE NUMBER: FAX NUMBER:

This form is the original. The pharmacy (or pharmacist) whose name appears above is the only recipient. The original of this form will not be reused.

INFORMATION ON THE INDICATION FOR POST-EXPOSURE PROPHYLAXIS (PEP)

☐ The person meets all the criteria in the 'CLINICAL SITUATION' section of the collective prescription.

☐ There are no contraindications to using this collective prescription.

☐ After an informed discussion, the person (or parent/legal representative) has opted for PEP.

DRUG IDENTIFICATION AND DOSAGE

Name of drug: Doxycycline

Age	Dosage	
☐ < 12 years	☐ Weight < 45 kg: 4.4 mg/kg (max.: 200 mg) PO as a single dose	Child's actual weight = ____ kg The child is able to swallow tablets: ☐Yes ☐No
	☐ Weight ≥ 45 kg: 200 mg PO as a single dose	
☐ ≥ 12 years	200 mg PO as a single dose	

The drug should be dispensed as soon as possible and no later than ____ a.m./p.m. on _ _ _ _ / _ _ / _ _ (YYYY/MM/DD) (maximum of 72 hours from tick removal to PEP dosing).

IDENTIFICATION OF THE HEALTH PROFESSIONAL WHO EXECUTES THE PRESCRIPTION

NAME:

PRACTICE LICENSE NUMBER:

TELEPHONE NUMBER:

SIGNATURE: DATE:

PRESCRIBING PHYSICIAN IDENTIFICATION

NAME:

PRACTICE LICENSE NUMBER:

TELEPHONE NUMBER:

FAX TRANSMITTAL TO COMMUNITY PHARMACY

(to be completed only if the sender is different from the authorized professional)

SENDER'S NAME:

DATE AND TIME FAX SENT: