

(For use by clinic / point of care as an individual administration record)

Patient Name: _____ DoB (dd/mmm/yyyy): _____

Parent / Legal Guardian Name: _____ Provincial Health #: _____

Phone: _____ Provincial Reference #: _____

Other Phone / Contact: _____

Circle #doses approved

3 4

Dosing 15mg/kg

2nd dose 3-4 weeks after 1st

Subsequent doses 4-5 weeks apart

Consent obtained? NO YES

Course complete? NO YES

Eligibility Criteria:

Dose #	When Taken	Where Dose Was Administered	Date (dd/mmm/yy)	Lot Number	Weight (kg)	Expiry Date	Dose (mg)	Admitted with any respiratory infection in previous month?	Admitted with RSV+ infection in previous month?	Clinic for next dose?
1		<input type="checkbox"/> No <input type="checkbox"/> Yes, at: _____						<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes, to: _____
2	3-4 weeks after Dose 1	<input type="checkbox"/> No <input type="checkbox"/> Yes, at: _____						<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes, to: _____
3	4-5 weeks after Dose 2	<input type="checkbox"/> No <input type="checkbox"/> Yes, at: _____						<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes, to: _____
*NOTE: the standard administration is three to four doses; a fifth dose may only be given to patients who have undergone cardiac bypass surgery.										
4 th ?	4-5 weeks after Dose 3	<input type="checkbox"/> No <input type="checkbox"/> Yes, at: _____						<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes, to: _____
5 th ?		<input type="checkbox"/> No <input type="checkbox"/> Yes, at: _____						<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes, to: _____
Final f/up		<input type="checkbox"/> No <input type="checkbox"/> Yes, at: _____						<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes, to: _____

At the end of each day, fax this page to the RSV Program and to any clinic that the patient attends. 604-875-2879 or 1-877-625-7555

If the patient has been hospitalized for any respiratory infection, then please fill out a Hospitalization Data form and send to

rsv@cw.bc.ca. BC RSV Immunoprophylaxis Program, as of 2018/19 Season