

ANTIVIRAL TREATMENT REPORTING

Please complete and fax the form to (608) 267-2832. **(Items in bold are required fields).**
For questions about the form please contact (608) 266-9691.

Patient Information

Name (Last, First MI): _____

Date of Birth: ____/____/____

Street Address: _____

City: _____

State (if not Wisconsin): _____ **Zip:** _____

Phone: (_____) _____ - _____

Provider Information

Hospital/ Clinic Name: _____

Ordering Authority: _____

Administering Clinician/Pharmacist: _____

Treatment Information:

Date Administered: ____/____/____

Product (including dosage): _____

NDC/Mfr Item Number: _____

Lot number: _____

Expiration Date: ____/____/____