Manitoba
Health
Public Health

Meningococcal/Drug Order Worksheet

Date: _____ Index Case Name : _____
mm/dd/yyyy

Case #	Last Name	First Name	Address and Postal Code	Phone #	Date of Birth mm/dd/yyyy	sex	PHIN	Prophylaxis yes	Prophylaxis no	Weight (kg)	**Medication Ordered (eg. Rifampin or Ciprofloxacin)**	Type of Contact & Date	Allergy

Interviewer _____
(include: name, phone number, professional designation)

December 23, 2005