Drug treatments for people with influenza who are critically ill

Australian guideline

DRUG TREATMENTS FOR ADULTS

DRUG TREATMENTS FOR CHILDREN

GUIDELINE REPORTS

ABOUT THIS GUIDELINE

The Australian guideline for drug treatments for people with influenza who are critically ill has been developed and published by the Australian Living Evidence Collaboration, in partnership with peak bodies for health professionals who provide care for people with influenza who are critically ill.

Status
This guideline provides Interim Advice. It is currently undergoing public consultation and will be submitted to NHMRC for approval.

This is the first version of the guideline.

Scope
The guideline aims to support health professionals in Australia in critical decision-making about drug treatments for people with influenza who are critically ill.

Target Audience
It is designed for use by health professionals in Australia responsible for clinical decision-making about drug treatments for people (adults and children) with influenza who are critically ill.

Individuals such as policymakers, researchers and students may elect to use or adopt these recommendations for other purposes; however these individuals are not the target audience and additional considerations not addressed within this guideline may be required for these uses.

Funding
The Guidelines Group is funded as part of an NHMRC Ideas Grant (2048195).

Impact Measures
The primary implementation outcome of the guideline is a reduction in rates of prescription of oseltamivir in people with influenza who are critically ill. Data from the **SPRINT-SARI registry** will be used to evaluate the impact of the guideline on this outcome.

How to cite
[APA style] Australian Living Evidence Collaboration. (2026 version 1). Australian guidelines for drug treatments for people with influenza who are critically ill. https://livingevidence.org.au/

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SUMMARY OF THE GUIDELINE AND CLINICAL QUESTIONS

Plain Language Summary

This guideline provides recommendations to support health professionals (doctors, nurses, pharmacists and others) in Australia to decide on the best drug treatments for adults and children who have influenza ('flu') and whose illness is life-threatening and causing their vital organs (like the heart, lungs, or brain) to fail. Usually, but not always, these people will be receiving care in a specialised hospital unit, like an intensive care unit (ICU) or a high dependency unit (HDU).

The recommendations in this guideline do not apply to mild influenza, which is usually treated in the community or at home. They also do not apply to treatment of people with more severe influenza that is not life-threatening, even when they are being treated in hospital.

Executive Summary and Clinical Questions

This guideline provides recommendations about the use of drug treatments for adults and children with influenza who are critically ill.

Critical illness is defined as

- Acute actual or imminent failure of one or more vital organ systems, and
- Requirement for respiratory or haemodynamic support as a result of influenza

The guideline is designed to apply to all people with influenza who are critically ill, regardless of the location of their care.

The guideline does not apply to people with influenza who are not critically ill.

The drug treatments under consideration include:

- Antivirals: oseltamivir, baloxavir, peramivir, zanamivir
- Corticosteroids
- Macrolides

Clinical questions are addressed in two age groups (Adults >12yrs, and Children ≤12yrs). This categorisation was selected on the basis of impact of body size on pharmacokinetics of the drug treatments and the inclusion criteria of relevant clinical trials.

KEY INSIGHTS FROM PEOPLE WITH LIVED EXPERIENCE

Lived Experience Panel members agreed that for people with influenza who are critically ill, drug treatments should offer meaningful benefit. There was low tolerance for treatments that are ineffective or offer only small or uncertain benefit, especially where harm is possible.

The Panel highlighted that, when deciding whether or not to provide drug treatments, people being treated for influenza who are critically ill, as well as their families and carers, support evidence-based decisions when they are:

- clearly explained
- transparent about uncertainty
- inclusive of patient and family input
- respectful of individual values.

The Lived Experience Panel emphasised that clinical recommendations must be accompanied by clear expectations for communication and shared decision-making. They noted that acceptability of treatment decisions was highly dependent on how decisions were made and communicated, rather than the decision itself. They noted that communication is not just about information-sharing—it is central to trust, safety, acceptability of care and effective implementation of guideline recommendations.

> *It started as influenza. Within days I was fighting for my life. I woke in ICU not knowing where I was, or why I was there. The delirium meant I didn't know who to trust, I believed everyone around me was trying to hurt me.*
>
> *The pain was relentless. The thirst was insatiable. Being suctioned through the tracheostomy was its own kind of suffering.*
>
> *My husband was given a clear and empathetic picture of how serious things were from the beginning. He said, honesty, as hard as it was to hear, mattered. My husband believes that his active involvement in treatment decisions made them feel less helpless in an otherwise helpless situation.*
>
> *If there is one thing that could have been better, it was preparation for what came after. Being informed about delirium, what it is, what it looks like and more about what recovery actually looks like.*
>
> *Every small thing that happens to you in ICU can feed the delirium. I didn't feel like a patient, I felt like I was being harmed. And I want clinicians to know that the inner world of an ICU patient can be far darker than anyone on the outside realises.*
>
> *What I needed, more than almost anything, was to feel safe. To be reminded of that often, not once. Talk to me, not about me. Presume I can hear you. I am a person, not just a body in a bed. And touch me. Hold my hand. The comfort that brought me, in the middle of all that fear and pain, was beyond words.*
>
> *Kerri, former ICU patient*

The Lived Experience Panel also highlighted equity issues, noting that people with lower health literacy, language barriers or less confidence in healthcare settings can be at a disadvantage in understanding and engaging with treatment decisions. In these contexts, patients and families rely heavily on trust, often without fully understanding what is happening. This increases vulnerability to poor experiences and suboptimal decision-making. They highlighted that the guidelines should therefore support approaches that assume variable health literacy, including plain language communication and checking understanding rather than assuming it.

Lived Experience Panel members recognised the realities of care for people who are critically ill including time pressure, multiple teams, and high clinical complexity, and they identified practical barriers to effective implementation of patient-centred care, particularly:

- inconsistent communication between clinicians
- limited opportunities for families to ask questions
- variability in how information is explained.

They suggested several simple, feasible strategies to improve communication, including:

- regular updates to families
- clear and simple explanations
- explicit opportunities to ask questions

The Lived Experience Panel also highlighted the role of carers and families, who may notice changes or adverse effects before clinicians, in promoting safe care, and emphasised that their concerns need to be taken seriously.

> *My daughter has a rare genetic disorder and is three years post liver transplant. Although the transplant went well, she deteriorated just 12 hours later and developed ARDS, and her condition became so critical that an ECMO machine was prepared. Thankfully, she recovered after a ten-day stay in PICU. For our family, this experience was far more traumatic than the transplant itself. A year later, following a tonsillectomy, she again developed significant respiratory distress after extubation and required a 3-day PICU admission.*
>
> *While in the PICU, being included in ward rounds was important. Hearing the team's discussions, understanding the reasons behind changing/ withholding treatments, and having our perspectives considered made us feel like partners in our daughter's care. We valued clinicians who clearly explained the benefits and risks of different treatment options and shared what they believed was the best course of action. During emergencies it is important for parents to step back while the team focuses on the patient, then ask questions once the situation has stabilised. For clinicians caring for children with severe respiratory distress, clear, timely communication with families is essential. Keep parents informed of significant changes, even if they are not at the bedside, and be transparent about what is happening and why. During emergencies, if possible, having one team member dedicated to communicating with the family can make an incredibly stressful situation feel more manageable and help families feel informed and included.*
>
> *Aisha, mother to a then 6-year old who was in PICU*

GUIDELINE DEVELOPMENT PROCESS

The development process for this guideline began on 11 June 2026.

Clinical expertise was sought via a multidisciplinary Guidelines Leadership Group and a Paediatric Clinical Panel. Lived experience contributions were provided by a Lived Experience Panel.

Recommendations were reviewed and endorsed by peak bodies for health professionals who provide care for people with influenza who are critically ill.

The guideline was published as Interim Advice undergoing public consultation on July 8 2026.

All evidence reviews, convening, guideline writing, publication and secretariat functions were undertaken by the Australian Living Evidence Collaboration.

Steering Committee

- **Australasian Society for Infectious Diseases**
- **Australasian College for Emergency Medicine**
- **Australian College of Critical Care Nurses**
- **Thoracic Society of Australia and New Zealand**
- **Australian and New Zealand Intensive Care Society**
- **College of Intensive Care Medicine**
- **Advanced Pharmacy Australia**
- **Australian College of Nursing**
- **Australia & New Zealand Musculoskeletal Clinical Trials Network**

- Australian Association of Gerontology
- Heart Foundation
- Australian College of Rural and Remote Medicine
- Australian Society of Anaesthetists

Guidelines Leadership Group Members

- Steve McGloughlin (Chair), Intensive Care Specialist and Infectious Diseases Physician
- Bradley Wibrow, Intensive Care Specialist
- Matthew Anstey, Intensive Care Specialist
- Craig French, Intensive Care Specialist
- Bronwyn Avard, Intensive Care Specialist
- Priya Nair, Intensive Care Specialist
- Cath Tacon, Intensive Care Specialist
- Kiran Shekar, Intensive Care Specialist
- Bridget Barber, Infectious Diseases Physician
- Josh Davis, Infectious Diseases Physician
- Gail Matthews, Infectious Diseases Physician
- Allen Cheng, Infectious Diseases Physician & Public Health
- Lucy Burr, Respiratory Physician
- Carol Hodgson, Physiotherapist (Intensive Care)
- Melissa Ankravs, Intensive Care Pharmacist
- Kelly Cairns, Senior Pharmacist
- Ingrid Hopper, Clinical Pharmacologist
- Brett Mitchell, Nursing, infection prevention & control
- Brendan Carrigan, Rural Generalist
- Jane Davies, Infectious Diseases and General Medicine Physician
- Sandra Peake, Intensive Care Specialist
- Jason Roberts, Consultant Clinical Pharmacist
- Tara Anderson, Infectious Diseases Physician
- Ian Seppelt, Intensive Care Specialist
- Sonia Koning, Antimicrobial Stewardship Pharmacist

Paediatric Clinical Panel Members

- Brendan McMullan, Paediatric Infectious Disease Specialist
- Amanda Gwee, Paediatric Infectious Disease Specialist & Pharmacologist
- Chris Blyth, Paediatric Infectious Disease Specialist
- Simon Craig, Paediatric Emergency Physician
- Danielle Wurzel, Paediatric Respiratory Physician
- Theresa Cole, Paediatric Immunologist
- Zoy Goff, Paediatric Pharmacist
- Natalie Williamson, Remote Area General Practitioner
- Felix Oberender, Paediatric Intensivist
- Simon Erickson, Paediatric Intensivist
- David Tingay, Neonatologist
- Mark Moore, Nurse Practitioner

Lived Experience Panel Members

- Ben Homewood
- Cheryl Durston
- Fiona Clay
- Brian Beh
- Tamara Dennett
- Kerri Cosma
- Jordan Sheppard
- Aisha Kahn
- Sue Emery

HOW TO USE THIS GUIDELINE

The gradation of evidence quality and recommendation strength used is based on the Grading of Recommendations Assessment, Development and Evaluation (GRADE) framework. As such, the guideline consists of *Recommendations* and *Supporting Information*.

Recommendations

Recommendation for

Recommendation for

A strong recommendation is given when there is high-certainty evidence showing that the overall benefits of the intervention are clearly greater than the disadvantages. This means that all, or nearly all, patients will want the recommended intervention.

Recommendation against

Strong recommendation against

A strong recommendation against the intervention is given when there is high-certainty evidence showing that the overall disadvantages of the intervention are clearly greater than the benefits. A strong recommendation is also used when the examination of the evidence shows that an intervention is not safe.

Conditional Recommendation for

Conditional Recommendation for

A conditional recommendation is given when it is considered that the benefits of the intervention are greater than the disadvantages, or the available evidence cannot rule out a significant benefit of the intervention while assessing that the adverse effects are few or absent. This recommendation is also used when patient preferences vary.

Conditional Recommendation against

Conditional Recommendation against

A conditional recommendation is given against the intervention when it is judged that the disadvantages of the intervention are greater than the benefits, but where this is not substantiated by strong evidence. This recommendation is also used where there is strong evidence of both beneficial and harmful effects, but where the balance between them is difficult to determine. Likewise, it is also used when patient preferences vary.

Only in research settings

Only in research settings

An “only in research settings” recommendation is given when there is insufficient evidence to determine if an intervention is either beneficial or harmful. When an “only in research” recommendation is given, the panel recommends that the intervention should only be considered in research conducted with appropriate ethical approval. In any other circumstance, the intervention is not recommended.

Consensus Recommendation

Consensus Recommendation

A consensus recommendation can be given for or against the intervention. This type of recommendation is used when there is not enough evidence to give an evidence-based recommendation, but the panel still regards it as important to give a recommendation.

Supporting information

- Additional information: Contextual, clinical and lived experience information to support accurate interpretation and application of the recommendation.
- Evidence profile: The overall effect estimates and references to the studies.
- Summary: Overview and brief review of the underlying evidence.
- Certainty of the evidence:
  High: We are very sure that the true effect is close to the estimated effect.
  Moderate: We are moderately sure of the estimated effect. The true effect is probably close to this one, but there is a possibility that it is significantly different.
  Low: We have limited confidence in the estimated effect. The true effect may be significantly different from the estimated effect.
  Very low: We have very little confidence in the estimated effect. The true effect is likely to be significantly different from that estimated effect.
- Evidence to decision: Brief description of beneficial and harmful effects, certainty of evidence and considerations of patient preferences and other elements of decision-making.
- Rationale: Description of how the above elements were weighted in relation to each other and resulted in the current recommendation direction and strength.
- References: Reference list for the recommendation.

HOW TO PROVIDE FEEDBACK ON OUR RECOMMENDATIONS

We welcome your feedback on the below recommendations and supporting information.

Click here for the feedback form

Or email us at admin.alec@monash.edu

ADULTS

>12 years

Click on the arrow to see additional information

- Oseltamivir Strong recommendation against INTERIM ADVICE
  - Do not use oseltamivir in adults with confirmed or suspected influenza who are critically ill.

Additional information:

The recommendation applies to all adults with confirmed or suspected influenza who are critically ill, including those who are immunocompromised, experiencing shock, pregnant or with bacterial co-infection, irrespective of duration of symptoms.

In patients who have been receiving oseltamivir for treatment of severe influenza, discontinue oseltamivir if they become critically ill*.

The recommendation is based on results of a single trial (REMAP-CAP), which demonstrates no benefit and suggests an increased risk of mortality in critically ill patients who receive oseltamivir and standard care compared to standard care alone (moderate certainty evidence; see evidence report).

This finding does not change the existing evidence that oseltamivir is safe and reduces duration of symptoms in people with mild influenza in the community when administered within 48 hours of symptom onset.

The Lived Experience Panel considers that, based on the available evidence demonstrating no clinical benefit and an increased risk of harm in critically ill patients, informed patients or their substitute decision-makers would accept this strong recommendation to cease oseltamivir once critical illness has developed.

The Panel emphasises the importance of clear, compassionate and consistent communication with patients and families regarding the evidence, the rationale for treatment decisions, and the opportunity to participate in shared decision-making wherever possible.

* Critical illness is defined as:

- Acute actual or imminent failure of one or more vital organ systems, and
- Requirement for respiratory or haemodynamic support as a result of influenza

See Evidence Report

- Baloxavir Only in research settings INTERIM ADVICE
  - Do not use baloxavir for the treatment of confirmed or suspected influenza in adults who are critically ill outside of randomised trials with appropriate ethical approval.

Additional information:

There is presently no evidence to support the use of baloxavir to treat influenza in patients who are critically ill. Until such evidence is available, do not use baloxavir to treat influenza in this population unless they are enrolled in a clinical trial.

The Lived Experience Panel emphasises the importance of clear, compassionate and consistent communication with patients and families regarding the evidence, the rationale for treatment decisions, and the opportunity to participate in shared decision-making wherever possible.

See Evidence Report

> Peramivir Only in research settings INTERIM ADVICE

– Do not use peramivir for the treatment of confirmed or suspected influenza in adults who are critically ill outside of randomised trials with appropriate ethical approval.

Additional information:

There is presently no evidence to support the use peramivir to treat influenza in patients who are critically ill. Until such evidence is available, do not use peramivir to treat influenza in this population unless they are enrolled in a clinical trial.

The Lived Experience Panel emphasises the importance of clear, compassionate and consistent communication with patients and families regarding the evidence, the rationale for treatment decisions, and the opportunity to participate in shared decision-making wherever possible.

See Evidence Report

> Zanamivir Only in research settings INTERIM ADVICE

– Do not use zanamivir for the treatment of confirmed or suspected influenza in adults who are critically ill outside of randomised trials with appropriate ethical approval.

Additional information:

There is presently no evidence to support the use of zanamivir to treat influenza in patients who are critically ill. Until such evidence is available, do not use zanamivir to treat influenza in this population unless they are enrolled in a clinical trial.

The Lived Experience Panel emphasises the importance of clear, compassionate and consistent communication with patients and families regarding the evidence, the rationale for treatment decisions, and the opportunity to participate in shared decision-making wherever possible.

See Evidence Report

> Corticosteroids Only in research settings INTERIM ADVICE

– Do not use corticosteroids for the treatment of confirmed or suspected influenza in adults who are critically ill outside of randomised trials with appropriate ethical approval.

Additional information:

There is presently no evidence to support the use of corticosteroids to treat influenza in patients who are critically ill. Until such evidence is available, do not use corticosteroids to treat influenza in this population unless they are enrolled in a clinical trial.

Corticosteroids may still be considered for other evidence-based indications in adults who have influenza and are critically ill, such as chronic obstructive pulmonary disease (COPD), septic shock or adrenal suppression.

The Lived Experience Panel emphasises the importance of clear, compassionate and consistent communication with patients and families regarding the evidence, the rationale for treatment decisions, and the opportunity to participate in shared decision-making wherever possible.

See Evidence Report

> Macrolides Only in research settings INTERIM ADVICE

– Do not use macrolides for the treatment of confirmed or suspected influenza in adults who are critically ill outside of randomised trials with appropriate ethical approval.

Additional information:

There is presently no evidence to support the use of macrolides to treat influenza in patients who are critically ill. Until such evidence is available, do not use macrolides to treat influenza in this population unless they are enrolled in a clinical trial.

Macrolides may still be considered for other evidence-based indications in adults who have influenza and are critically ill, such as atypical secondary bacterial infection, gastrointestinal motility and asthma.

The Lived Experience Panel emphasises the importance of clear, compassionate and consistent communication with patients and families regarding the evidence, the rationale for treatment decisions, and the opportunity to participate in shared decision-making wherever possible.

See Evidence Report

CHILDREN

≤12 years

Click on the arrow to see additional information

> Oseltamivir Conditional Recommendation against INTERIM ADVICE

– Do not use oseltamivir for the treatment of children with confirmed or suspected influenza who are critically ill with respiratory failure.

Additional information:

This recommendation applies to all children experiencing respiratory failure with confirmed or suspected influenza who are critically ill*, irrespective of age, including those who are immunocompromised, experiencing shock or with bacterial co-infection. Oseltamivir may still be considered for other indications in children with influenza who are critically ill and who are not presenting with respiratory failure, such as those with Acute Necrotizing Encephalopathy (ANE) or myocarditis (see associated consensus recommendation).

There is currently no direct evidence regarding the safety and efficacy of oseltamivir in treating influenza in children aged ≤12 years who are critically ill. The recommendation is based on results of a single trial (REMAP-CAP) comparing oseltamivir and standard care to standard care alone in adults with influenza who are critically ill. Results of the study show that oseltamivir probably provides no benefit and may lead to potential harms (low certainty evidence due to serious risk of bias and serious indirectness).

This finding does not change the existing evidence that shows that oseltamivir is safe and reduces duration of symptoms in children with mild influenza in the community when administered within 48 hours of symptom onset.

The Lived Experience Panel considers that, based on the available evidence demonstrating no clinical benefit and an increased risk of harm in adults with influenza who are critically ill, parents, caregivers and guardians would choose not to proceed with this treatment for their child.

The Panel emphasises the importance of clear, compassionate and consistent communication with patients and families regarding the evidence, the rationale for treatment decisions, and the opportunity to participate in shared decision-making wherever possible.

* Critical illness is defined as:

- Acute actual or imminent failure of one or more vital organ systems, and
- Requirement for respiratory or haemodynamic support as a result of influenza

See Evidence Report

> Oseltamivir Consensus Recommendation INTERIM ADVICE

– The use of oseltamivir may be considered on a case-by-case basis for the treatment of non-respiratory presentations in children with influenza who are critically ill, following consultation with appropriate specialists.

Additional information:

There is currently no direct evidence regarding the safety and efficacy of oseltamivir in treating influenza in children ≤ 12 years who are critically ill. Indirect evidence in adults with community-acquired pneumonia suggests that oseltamivir may provide no benefit with a potential for harm (REMAP-CAP).

The use of oseltamivir may still be considered for use in children with influenza who are critically ill and have non-respiratory presentations, such as influenza-associated encephalitis/encephalopathy, severe neurologic deficit or myocarditis. Decisions to treat should be made in consultation with appropriate specialists, including intensive care and infectious disease physicians.

The Lived Experience Panel emphasises the importance of clear, compassionate and consistent communication with patients and families regarding the evidence, the rationale for treatment decisions, and the opportunity to participate in shared decision-making wherever possible.

See Evidence Report

> Baloxavir Only in research settings INTERIM ADVICE

– Do not use baloxavir for the treatment of confirmed or suspected influenza in children who are critically ill outside of research settings.

Additional information:

There is currently no evidence to support the use of baloxavir to treat influenza in children who are critically ill. Until such evidence is available, do not use baloxavir to treat influenza in this population unless they are participating in research. Due to the low number of children with influenza who experience critical illness, research should not be limited to randomised controlled trials and may include other study types that provide relevant evidence.

The Lived Experience Panel emphasises the importance of clear, compassionate and consistent communication with patients and families regarding the evidence, the rationale for treatment decisions, and the opportunity to participate in shared decision-making wherever possible.

See Evidence Report

> Peramivir Only in research settings INTERIM ADVICE

– Do not use peramivir for the treatment of confirmed or suspected influenza in children who are critically ill outside of research settings.

Additional information:

There is currently no evidence to support the use of peramivir to treat influenza in children who are critically ill. Until such evidence is available, do not use peramivir to treat influenza in this population unless they are participating in research. Due to the low number of children with influenza who experience critical illness, research should not be limited to randomised controlled trials and may include other study types that provide relevant evidence.

The Lived Experience Panel emphasises the importance of clear, compassionate and consistent communication with patients and families regarding the evidence, the rationale for treatment decisions, and the opportunity to participate in shared decision-making wherever possible.

See Evidence Report

> Zanamivir Only in research settings INTERIM ADVICE

– Do not use zanamivir for the treatment of confirmed or suspected influenza in children who are critically ill outside of research settings.

Additional information:

There is currently no evidence to support the use of zanamivir to treat influenza in children who are critically ill. Until such evidence is available, do not use zanamivir to treat influenza in this population unless they are participating in research. Due to the low number of children with influenza who experience critical illness, research should not be limited to randomised controlled trials and may include other study types that provide relevant evidence.

The Lived Experience Panel emphasises the importance of clear, compassionate and consistent communication with patients and families regarding the evidence, the rationale for treatment decisions, and the opportunity to participate in shared decision-making wherever possible.

See Evidence Report

> Corticosteroids Only in research settings INTERIM ADVICE

– Do not use corticosteroids for the treatment of respiratory failure in children with confirmed or suspected influenza who are critically ill outside of research settings.

Additional information:

There is currently no evidence to support the use of corticosteroids to treat respiratory failure in children with influenza who are critically ill. Until such evidence is available, do not use corticosteroids to treat influenza in this population unless they are participating in research. Due to the low number of children with influenza who experience critical illness, research should not be limited to randomised controlled trials and may include other study types that provide relevant evidence.

Corticosteroids may still be considered for other evidence-based indications in children who have influenza and are critically ill, such as septic shock or adrenal suppression.

The Lived Experience Panel emphasises the importance of clear, compassionate and consistent communication with patients and families regarding the evidence, the rationale for treatment decisions, and the opportunity to participate in shared decision-making wherever possible.

See Evidence Report

> Macrolides Only in research settings INTERIM ADVICE

– Do not use macrolides for the treatment of confirmed or suspected influenza in children who are critically ill outside of research settings.

Additional information:

There is currently no evidence to support the use of macrolides to treat influenza in children who are critically ill. Until such evidence is available, do not use macrolides to treat influenza in this population unless they are participating in research. Due to the low number of children with influenza who experience critical illness, research should not be limited to randomised controlled trials and may include other study types that provide relevant evidence.

Macrolides may still be considered for other evidence-based indications in children who have influenza and are critically ill, such as atypical secondary bacterial infection, asthma or for gastrointestinal motility.

The Lived Experience Panel emphasises the importance of clear, compassionate and consistent communication with patients and families regarding the evidence, the rationale for treatment decisions, and the opportunity to participate in shared decision-making wherever possible.

See Evidence Report

Feedback form

We welcome your feedback on all of the above to aid the development of this guideline and ensure it is useful for intended users. Your feedback will be read by the ALEC team and carefully considered. All feedback and any subsequent responses or changes to the guideline will be recorded and publicly available in the Public Consultation Submissions Summary.

We would greatly value your feedback regarding the following questions:

Can you suggest improvements to the recommendations, additional information or related resources?
Do you think any particular groups of people would have different preferences to the recommended option?
Do you have any comments on the resources required or the feasibility of the recommended option?
Do you have any concerns about equity if the recommended option is implemented?

Your feedback

Guideline section

eg. Baloxavir in adults

Feedback

Add more feedback

Your Details

Full Name *

Email *

Organisation and/or profession

Country *

Please select from the dropdown list

Are you responding as an individual or on behalf of an organisation?

- [ ] Individual
- [ ] Organisation (Please specify)

Do you have any conflicts of interest to declare?

- [ ] No
- [ ] Yes (Please specify)

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For more information about Data Protection and Privacy at Monash University please see our Data Protection and Privacy Procedure.

If you have any questions about how Monash University is collecting and handling your personal information, please contact our Data Protection and Privacy Office at dataprotectionofficer@monash.edu.

Consent *

☐ I understand my feedback will be shared with the National Health and Medical Research Council and will be published online. (Only your feedback is published, not your details)

☐ I consent to the information that I provide to be used by ALEC and Monash University to improve their clinical practice guidelines.

☐ I have read and understood the Monash University Research Data Protection and Privacy Collection Statement.

☐ I am human hCaptcha Privacy - Terms

SUBMIT

These guidelines have been developed for health professionals. We advise that people with influenza, their carers and people in the community only use these guidelines in conjunction with the advice of a healthcare professional.

The recommendations contained in this guideline do not replace the need for medical, personal and professional judgment regarding individual presentation, location and circumstances.

The Guideline Group have made every effort to ensure the information within this guideline is accurate and up to date and accept no responsibility for any inaccuracies, information perceived as misleading, or the success or failure of any treatment detailed in the guideline.

We recommended that users confirm through a variety of sources that the information contained within this guideline is correct, particularly for medications.

REPORTS

- Evidence Report
- Technical Report
- Administrative Report
- Terms of Reference
- Conflicts of Interest Procedure
- Sample DOI Form
- Public Consultation Submission Summary

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