PHARMACIST ASSESSMENT – MILD ACNE

Patient information:

Name:	HSN:	
Address:	DOB:	Sex: ☐ male ☐ female
Telephone:	☐ Pregnant ☐ Lactating	

Medical History:

Drug History/ Drug allergies:

Patient History:

Is the patient pregnant, younger than 12 years of age, older than 30 years of age?
☐ No → Continue ☐ Yes →Refer

Does the patient have family history of scarring acne?

☐ No → Continue ☐ Yes → Refer

Is the patient using medication that could cause / worsen acne (e.g. glucocorticoids, lithium, androgens, phenytoin, etc.)

☐ No → Continue ☐ Yes → Refer to rule out drug-induced acne

Has the patient previously been diagnosed with acne by a primary care provider?

☐ Yes ☐ No

Has the patient tried any non-pharmacologic or pharmacologic treatment for acne?
☐ No ☐ Yes → **What?** _____ **Effect?** _____

Review of Symptoms:

Does the patient have any alarm signs / symptoms (fever or arthralgia, hyperandrogenism (eg. scalp hair loss, facial hair, etc.)?
☐ No → Continue ☐ Yes → Refer

Does the patient have signs / symptoms warranting referral to physician?
☐ Approximate more than 20 comedones present
☐ Approximate more than 15 inflammatory papules present
☐ Total lesion count greater than 30
☐ Erythema, papules, pustules in the absence of comedones (other conditions must be ruled out)
☐ Widespread inflammatory lesions (i.e. involving areas beyond the face)
☐ High levels of anxiety, low self-esteem
☐ Unable to confirm patient self-diagnosis (See Differential Assessment)
☐ None → Continue ☐ Yes to any → Refer

Has the patient been practicing optimal skin care?
☐ Yes → Continue ☐ No → Include skin care education in treatment plan and continue

Patient has primarily comedonal acne (white-blackheads and no inflamed lesions)?
☐ No → Continue ☐ Yes → Proceed to Treatment #1

Patient has mild inflammatory acne (papules, pustules +/- comedones)?
☐ Yes → Proceed to Treatment #2 or #3

☐ Unsatisfactory improvement after 8 – 12 weeks of topical retinoid ?
→ Consider Treatment #2, #3 or #4 OR refer

☐ Unsatisfactory improvement after 8 – 12 weeks of benzoyl peroxide?
→ Consider Treatment #1, #3 or #4 OR refer

☐ Unsatisfactory improvement after 8 – 12 weeks of benzoyl peroxide + retinoid?
→ Consider Treatment #4 or refer

☐ Maintenance therapy with: topical retinoid indicated?
→ Refer

Treatment:

☐ 1: Prescribe retinoid. Reassess in 8 weeks.

☐ 2: Recommend topical benzoyl peroxide. Reassess in 8 weeks

☐ 3: Prescribe retinoid + benzoyl peroxide combination. Reassess in 8 weeks

☐ 4: Prescribe topical antibiotic in addition to current therapy or combination product (antibiotic + retinoid or benzoyl peroxide. Reassess in 8 weeks.

Prescription Issued for Minor Ailment

Rationale for prescribing:

Rx: (Name, strength)

Quantity (max of 8 weeks, or 4 weeks plus one refill):

Dosage directions:

pseudoDIN: 00951087

Counseling / Monitoring:

☐ Patient may see initial worsening for the first 2 to 4 weeks
☐ May take 8 – 12 weeks for maximum benefit
☐ Provide method for gradual titration of application time to reduce skin irritation

Follow-up scheduled in 8 weeks: (date) _____

☐ In pharmacy ☐ Telephone

☐ Patient's acne has responded well. Contact MD for authorization of refills or switch to maintenance therapy.

☐ No or unsatisfactory response but acne not worse. Go to Treatment #3 or #4 OR refer.
MAXIMUM OF TWO TRIALS OF TOPICAL PRESCRIPTION PRODUCTS BEFORE REFERRAL

☐ Patient's acne has worsened. Refer

☐ Discontinued therapy due to adverse effects – Reassess, consider alternate treatments and / or refer

Prescribing Pharmacist:

Name:
Pharmacy:
Tel: Fax: Email:

Signature	Date:
Primary Care Provider:	**Fax Number:**

Pharmacist Minor Ailment Prescribing Record

To

This document is to inform you I met with your patient below who presented with **mild acne**. After an assessment, a prescription was issued for

The prescription details and rationale for my decision are documented below. This is for your information to keep your records for this patient up to date.

Patient Demographics:

Name:	HSN:	
Address:	DOB:	Gender: ☐ male ☐ female
Telephone:	☐ Pregnant ☐ Breastfeeding	

Prescription Issued on _____

MEDICATION:

DIRECTIONS:

QUANTITY:

Rationale for prescription / relevant patient information:

I will follow-up with the patient on _____ and discuss these items:

☐ Patient's acne has responded well. Contact patient's doctor for authorization of refills or switch to maintenance therapy.
☐ No or unsatisfactory response but acne not worse. Try alternate treatment OR refer to patient's doctor. MAXIMUM OF TWO TRIALS OF TOPICAL PRESCRIPTION PRODUCTS BEFORE REFERRAL
☐ Patient's acne has worsened. Refer.
☐ Discontinued therapy due to adverse effects – Reassess, consider alternate treatments and / or refer

Prescribing Pharmacist:

Name:	Signature:
Name of Pharmacy:	Telephone:
Email:	Fax:
Primary Care Provider Notified:	
Name:	Fax: