PHARMACIST ASSESSMENT - ALLERGIC RHINITIS

Patient Information		
Name:	HSN:	
Address:	DOB:	Sex: ☐ male ☐ female
Telephone:	☐ Pregnant ☐ Lactating	
Medical History:		
Drug History/ Drug allergies:		

Patient History

Is the patient ≤ 2 years of age?

☐ No → Continue ☐ Yes→ Refer

Is the patient pregnant?

☐ No → Continue ☐ Yes → Refer

Does the patient have asthma, recurrent or chronic sinusitis, or otitis media?

☐ No → Continue ☐ Yes → Refer

Is the patient taking a medication suspected of causing the symptoms (ASA, NSAID, ACE-inhibitor, alpha blocker, beta blocker, etc.)?

☐ No → Continue ☐ Yes → Recommend stopping or changing medication and / or refer

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

☐ Yes ☐ No

Has the patient tried any pharmacologic or non-pharmacologic treatment for symptoms?

☐ No ☐ Yes → What was tried?

What was the effect?

Review of Symptoms

Does the patient have symptoms which suggest anaphylaxis?

☐ No → Continue ☐ Yes → Medical help needed immediately

Does the patient have shortness of breath, persistent headache, eye pain?

☐ No →Continue ☐ Yes to any → Refer

Does the patient have symptoms consistent with allergic rhinitis?

☐ Sneezing

☐ Rhinorrhea

☐ Nasal congestion

☐ Itchy eyes /throat

☐ Yes → Continue ☐ No → Consider other conditions / refer

Does the patient have symptoms primarily in one nostril?

☐ No → Continue ☐ Yes → Refer

How long have the symptoms been present?

☐ 7 days or longer → Continue ☐ Less than 7 days → Consider upper respiratory tract infection

How severe are the symptoms?

Mild (able to perform normal activities and sleep normally)

☐ Intermittent→ OTC treatment PRN

☐ Frequent or persistent → Consider prescription for intranasal corticosteroid

Moderate to Severe (symptoms interfere significantly with normal activities and/or sleep)

☐ Intermittent → Consider prescription for intranasal corticosteroid

☐ Persistent → Refer

Treatment

☐ Non-pharmacologic: allergen / irritant avoidance

☐ OTC: antihistamine, oral decongestant PRN for **mild, infrequent symptoms**

☐ Intranasal corticosteroid for **mild, frequent or persistent** or **moderate, intermittent symptoms**

Prescription Issued for minor ailment

Rationale for prescribing:

Rx: (Name. strength)

Quantity (may provide enough for patient's allergy season):

Dosage Directions:

pseudoDIN: 00951090

Counseling

☐ Instructions on use of intranasal inhaler

☐ Expect relief of symptoms in 1 to 2 days; may take up to 2 weeks for maximum effect; if no response in 48 hours or symptoms worsen, contact your pharmacist or healthcare provider

☐ Allergen avoidance

Follow-up scheduled in 2 - 4 weeks (date):

☐ In pharmacy ☐ Telephone

☐ Symptoms resolved

☐ Symptoms improved, but require chronic therapy longer than allergy season --> Contact care provider

☐ Symptoms not improved --> Refer

Prescribing Pharmacist

Name:	Signature:
Pharmacy:	Telephone: Fax:
Email:	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 **allergic rhinitis.**

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:

☐ Symptoms resolved
☐ Symptoms improved, but require chronic therapy longer than allergy season --> Contact care provider
☐ Symptoms not improved --> Refer

Prescribing Pharmacist

Name:	Signature:
Pharmacy:	Telephone: Fax:
Email:	Date:

Primary Care Provider Notified

Name:	Fax: