

PHARMACIST ASSESSMENT – HEADACHE AND MIGRAINE

Patient		
Name:	HSN:	
Address:	DOB:	Gender: <input type="checkbox"/> male <input type="checkbox"/> female
Telephone:	<input type="checkbox"/> Pregnant <input type="checkbox"/> Lactating	
Medical History: <input type="checkbox"/> Renal dysfunction <input type="checkbox"/> Hepatic dysfunction <input type="checkbox"/> Cardiovascular or cerebrovascular disease		
Drug History/ Drug allergies:		
Patient History		
Is the patient over 50 years old and this is a new, undiagnosed headache? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Refer		
Is this the patient's first or worst headache? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Refer (refer to emergency if <u>worst</u> headache)		
Does the patient experience 6 or more headaches per month or significant impairment of quality of life due to headaches? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Refer for prophylactic therapy, but may still prescribe treatment in interim		
Has the patient had any recent head trauma? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Refer to emergency room		
Does the patient have uncontrolled hypertension? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Refer		
Is the patient on any medications which can cause headaches, or suffering from a medication withdrawal? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Refer to care provider, or contact to suggest management strategies		
Has the patient previously had their headache diagnosed by a primary care provider (helps self-diagnosis and EDS)? <input type="checkbox"/> Yes → tension headache <input type="checkbox"/> Yes → migraine <input type="checkbox"/> No → continue		
Has the patient tried any non-pharmacologic or pharmacologic treatment for their headache? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → What*? Effect? <small>*Triptan use within 12h of ergotamines (or 24h if naratriptan to be used) is contraindicated</small>		
Has the patient used any headache treatment for more than 10-15 days per month for 3 or more months? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Suspect medication overuse headache and refer, or contact care provider to suggest management strategies		
Does the patient have a history of, or risk factors for, cardiovascular or cerebrovascular disease? (see full treatment guidelines for definition of CVD and risk factors) <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Prefer treatment options other than NSAIDs; triptans contraindicated; consider referral		
Review of Symptoms		
Is the patient experiencing impairment of speech, sensation, strength or consciousness? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Refer to emergency room		
Is the patient experiencing a concurrent fever with neck stiffness? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Refer to emergency room		
Does the patient have unilateral eye pain, red eye, fixed and dilated pupil? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Refer to emergency room		
Is this headache different (pattern, symptoms, severity) than previous headaches? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Refer to emergency room		

Does the headache occur with exercise or sexual activity?

- No → Continue Yes → Refer

Is the pain greater than 6 on a scale of one to ten?

- No → Continue Yes → Consider referral

Are the symptoms consistent with a **migraine**?

Two or more of the following:

- Throbbing or pulsating pain Aggravated by activity Unilateral pain Lasts 4-72 hours

PLUS one of:

- Nausea Vomiting Photophobia Phonophobia

- No → Continue Yes → proceed to treatment

Are the symptoms consistent with a **tension** headache (two or more of the following)?

- Bilateral headache Mild-moderate intensity
 Non-pulsating pain (pressing / tightening pain) Not worsened by activity

- Yes → proceed to treatment No → diagnosis unsure, refer

Treatment recommended

- Suggest non-pharmacologic measures
 Mild tension headache or migraine: OTC doses of analgesics (acetaminophen or NSAIDs)
 Moderate tension headache or mild tension headache not relieved by optimal OTC measures already tried: Prescription dose of an NSAID
 Moderate migraine or mild migraine not relieved by optimal OTC measures already tried: Prescription dose NSAIDs or a triptan (see guideline for list of eligible products)
 If more than 8 headaches per month, strongly consider referral to prescriber for prophylactic therapy

Prescription Issued for minor ailment

Rationale for prescribing:

Rx:

Quantity (may prescribe enough to treat up to 4 headaches / migraines per prescription):

Directions:

pseudoDIN: 00951097

Counselling

- Non-pharmacologic management
 Optimal administration of medications (eg. loading dose for NSAIDs, triptan use and timing if aura present)
 Headache should be aborted within 2 to 6 hours
 Avoidance of medication overuse headaches
 Side effects of chosen treatment
 When initiating prophylactic therapy may be appropriate
 Keep a headache diary to detail number of headaches per month, triggers, and effectiveness of treatment

Follow-up scheduled on

- In pharmacy By telephone

- If possible, follow up within 24 hours to see if headache aborted
 Ask about side effects of medications
 Monitor for medication overuse headache at following visits
 If no improvement, try alternate option for future episode. Refer if two trials fail to provide improvement

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 a **primary headache**.

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: <input type="checkbox"/> male <input type="checkbox"/> female
Telephone:	<input type="checkbox"/> Pregnant <input type="checkbox"/> Lactating	

Prescription Issued on

MEDICATION:

DIRECTIONS:

QUANTITY:

Rationale for prescription / relevant patient information**I will follow-up with the patient on _____ and discuss these items:**

- If possible, follow up within 24 hours to see if headache aborted
- Ask about side effects of medications
- Monitor for medication overuse headache at following visits
- If no improvement, try alternate option for future episode. Refer if two trials fail to provide improvement

Prescribing Pharmacist

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

Primary Care Provider Notified

Name:	Fax:
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