

Treatment recommended

- General treatment measures:
- increase fibre and fluid intake
 - sitz bath
 - avoid long periods on the toilet
 - stool softener
 - avoid straining when using toilet
 - regular exercise
- OTC hemorrhoid product
- Prescription for hemorrhoidal product
(Note: OTC products should be used preferentially as first option, depending on patient preference)

Prescription Issued for minor ailment


Rationale for prescribing:

Rx (name, strength, FORM):

Quantity (provide 7 days at a time, with one refill):

Directions:

pseudoDIN: 00951098**Counselling / Monitoring**

- Advise on general measures, prevention and product use
- Expect improvement of symptoms in 48 hours or less
- If symptoms worsen, contact your pharmacist or 

Follow-up scheduled in 7 days:

- In pharmacy Telephone
- Symptoms resolved; ensure medication is discontinued and continue non-pharmacologic measures
- Symptoms not resolved but improved; continue for up to another 7 days
- 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 **non-severe hemorrhoids**.

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:

- Symptoms resolved; ensure medication is discontinued and continue non-pharmacologic measures
- Symptoms not resolved but improved; continue for up to another 7 days
- Symptoms not improved; refer

Prescribing Pharmacist

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

Primary Care Provider

Name:	Fax:
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