PHARMACIST ASSESSMENT -- HEMORRHOIDS

Patient information

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

Medical History:

Drug History/ Drug allergies:

Patient History

Is the patient less than 12 years of age?
☐ No → Continue ☐ Yes → Refer

Is the patient pregnant and in severe discomfort?
☐ No → Continue ☐ Yes → Refer

Does the patient have family or personal history of colorectal cancers, polyps?
☐ No → Continue ☐ Yes → Refer

Does the patient have a history of inflammatory bowel disease?
☐ No → Continue ☐ Yes → Refer

Has the patient previously been diagnosed with hemorrhoids by a primary care provider?
☐ No ☐ Yes

Has the patient had frequent, recurrent episodes of bleeding hemorrhoids?
☐ No → Continue ☐ Yes → Refer

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

Review of Symptoms

Does the patient have symptoms that suggest more serious disease?

- ☐ Bleeding dark in color, large amounts, small amounts lasting >6 weeks, or frequent recurrent episodes of bleeding hemorrhoids
- ☐ Mass protruding out of rectum needing manual replacement
- ☐ Severe pain
- ☐ Other:

☐ No → Continue ☐ Yes to any → Refer

Are symptoms consistent with the diagnosis of hemorrhoids?

- ☐ Burning, irritation, swelling, itching + / - pain in anal area
- ☐ Bright red blood on toilet paper, in toilet bowl
- ☐ Associated with constipation or diarrhea
- ☐ Palpable lump
- ☐ Straining with defecation

☐ Yes → Continue ☐ No, consider other causes, refer

Have the symptoms been present for more than 7 days despite treatment?
☐ No → Continue ☐ Yes → Refer

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 primary care provider

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: ☐ male ☐ female
Telephone:	☐ Pregnant ☐ 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: