PHARMACIST ASSESSMENT – MUSCULOSKELETAL PAIN

Patient		
Name:	HSN:	
Address:	DOB:	Gender: ☐ male ☐ female
Telephone:	☐ Pregnant ☐ Lactating	
Medical History: ☐ Renal dysfunction ☐ Hepatic dysfunction ☐ Cardiovascular disease		
Drug History/ Drug allergies: ☐ Statin use		

Patient History

Is the patient trying to conceive or in third trimester of pregnancy?
☐ No → Continue ☐ Yes → NSAID use contraindicated

Has the patient been diagnosed with osteoarthritis?
☐ No → Continue ☐ Yes → Refer to MD (if pain is primarily in joints)

Is the patient less than 2 years of age?
☐ No → Continue ☐ Yes → Refer to MD

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

Does the patient have a history of, or risk factors for, cardiovascular or cerebrovascular disease*?
**see treatment guidelines for definition of CVD and risk factors*
☐ No → Continue ☐ Yes → Prefer treatment options other than NSAIDs (particularly avoid diclofenac and celecoxib). Refer to MD if NSAID deemed necessary.

Review of Symptoms

Is there visible joint changes, abnormal movement, weakness in any limb, or suspected fracture?
☐ No → Continue ☐ Yes → Refer to MD

Does the patient have pelvic or abdominal pain (other than dysmenorrhea)?
☐ No → Continue ☐ Yes → Refer to MD

Is there accompanying nausea, vomiting, fever, or other signs of systemic infection or disorder?
☐ No → Continue ☐ Yes → Refer to MD

How long has the patient had pain?
☐ More than 2 weeks, or > 7 days with treatment, without improvement→ Refer to MD
☐ 2 weeks or less → Continue

How severe is the pain?
☐ Moderate to severe, or increased intensity → Refer to MD
☐ Mild to moderate (6 or less on pain scale of 1 to 10, and no significant impact on daily life) → Continue

Does the patient attribute the pain to overexertion or muscle or joint injury
☐ Yes → self-care appropriate, proceed to Treatment ☐ No → Refer to MD

Treatment recommended

☐ Initiate RICE

☐ Mild pain: OTC analgesics (topical or oral) and / or muscle relaxants for 7 days

☐ Moderate pain: Prescription NSAID for pain and stiffness for 7 days, refill X 1 PRN

Prescription Issued for minor ailment

Rationale for prescribing:

Rx:

Quantity (provide 7 days worth, may refill once – up to 14 days therapy total):

Directions:

pseuoDIN: 00951099

Counselling

☐ RICE therapy
☐ Expect onset of effect in 15 to 30 minutes
☐ If no response or symptoms worsen, contact your pharmacist or MD

Follow-up scheduled in 7 days:

☐ In pharmacy ☐ Telephone
☐ Symptoms improved or resolved: continue therapy for a maximum of 14 days in total; discontinue medication once symptoms have resolved
☐ Symptoms not improving: refer to MD
☐ Intolerable side-effects to medication: recommend different drug, assess administration (eg. with food), refer to MD

Prescribing Pharmacist:	
Name:	Signature:
Pharmacy:	Telephone: Fax:
Email:	Date:
Patient's Doctor: Dr.	**Doctor Fax Number:**

Pharmacist Minor Ailment Prescribing Record

To Dr.

This document is to inform you I met with your patient below who presented with **acute musculoskeletal pain.**

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 improved or resolved: continue therapy for a maximum of 14 days in total; discontinue medication once symptoms have resolved
☐ Symptoms not improving: refer to MD
☐ Intolerable side-effects to medication: recommend different drug, assess administration (eg. with food), refer to MD

Prescribing Pharmacist

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

Physician notified

Name: Dr.	Fax: