PHARMACIST ASSSESMENT – TINEA CORPORIS (RING WORM)

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

Patient History

Is the patient diabetic?
☐ No → Continue ☐ Yes → Refer

Is the patient immunocompromised (disease or drug-induced)?
☐ No → Continue ☐ Yes → Refer

Has the patient been in contact with persons with similar symptoms or pets / animals suspected of having ringworm?
☐ Yes → Supports patient's diagnosis

Has the patient previously been diagnosed with tinea corporis by a physician?
☐ Yes ☐ No

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

Review of Symptoms

Does the patient have fever, fatigue, swollen lymph glands or other symptoms of systemic illness?
☐ No → Continue ☐ Yes → Refer

Is this a previous ring worm infection that did not fully clear despite proper treatment?
☐ No → Continue ☐ Yes → Refer

Has one week of previous antifungal therapy yielded no improvement?
☐ No → Continue ☐ Yes → Refer

Do the lesions exhibit any of these severe characteristics?
- ☐ Extensive (circumference >10 cm ± multiple lesions)
- ☐ On the scalp
- ☐ Severely inflamed
- ☐ Weeping or purulent
- ☐ Painful
- ☐ Disabling

☐ No → Continue ☐ Yes → Refer

Are symptoms consistent with diagnosis of tinea corporis?
- ☐ Circular/oval red patch expanding outwards
- ☐ Raised scaly border, clear central area
- ☐ Lesion from 1 – 10 cm in diameter
- ☐ Lesions on face, neck, trunk or limbs

☐ Predominately yes → Continue ☐ No → consider other conditions / refer

Treatment

☐ Non-pharmacologic treatment measures

☐ OTC topical - clotrimazole, miconazole, or tolnaftate BID for 4 weeks

☐ Prescription antifungal (slightly more effective / more rapid acting)

Options:

☐ **Terbinafine 1% Cream** (children ≥12 and adults)
Apply adequate amount of cream to cover affected area and approximately 2cm beyond visible edge of lesions ONCE daily for 7 days.
Massage in gently.
Mitte: 30g

☐ **Terbinafine 1% Spray** (children ≥12 and adults)
Spray sufficient amount of solution to cover treatment area and surrounding skin ONCE daily for 7 days.
Mitte: 30ml

☐ **Ketoconazole 2% Cream**
Apply adequate amount of cream to affected area and approximately 2cm beyond visible edge of lesions ONCE daily for 3 to 4 weeks.
Massage in gently.
Mitte: 30g

Prescription Issued for minor ailment

Rationale for prescribing:

Rx:

Quantity (7 days for terbinafine; 3-4 weeks for ketoconazole):

Directions:

pseudoDIN: 00951101

Counselling

☐ Adjunctive measures to ensure positive outcomes
☐ Duration of therapy (and to extend 1 week after symptoms resolve unless using terbinafine)
☐ Appropriate application area
☐ If no improvement after 1 week of pharmacologic treatment, or if symptoms worsen, consult primary care provider

Follow-up scheduled in 7 days:

☐ In pharmacy ☐ Telephone
☐ If worsening or no improvement, refer
☐ If improving, encourage continued treatment for appropriate duration and for 1 week after symptoms resolve (unless using terbinafine)

Prescribing Pharmacist:

Name:	Signature:
Pharmacy:	Telephone: Fax:
Email:	Date:
Primary Care Provider:	**Doctor Fax Number:**

Pharmacist Minor Ailment Prescribing Record

To

This document is to inform you I met with your patient below who presented with **tinea corporis.**

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:

☐ If worsening or no improvement, refer
☐ If improving, encourage continued treatment for appropriate duration and for 1 week after symptoms resolve (unless using terbinafine)

Prescribing Pharmacist	
Name:	Signature:
Pharmacy:	Telephone: Fax:
Email:	Date:
Primary Care Provider Notified	
Name:	Fax: