

PHARMACIST ASSESMENT – TINEA CRURIS (JOCK ITCH)

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:		
Drug History / Drug allergies:		
Patient History		
Is the patient diabetic? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Refer		
Is the patient immunocompromised (disease or drug-induced)? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Refer		
Does the patient have risk factors for tinea cruris? <input type="checkbox"/> Previous tinea cruris infection <input type="checkbox"/> Patient participates in sports or is prone to sweating <input type="checkbox"/> Patient wears tight-fitting clothing for extended periods of time <input type="checkbox"/> Yes to any → Supports patient's diagnosis		
Has the patient previously been diagnosed with tinea cruris by a primary care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the patient tried any non-pharmacologic or pharmacologic treatment for tinea cruris? <input type="checkbox"/> No <input type="checkbox"/> Yes → What? _____ Effect? _____		
Review of Symptoms		
Does the patient have fever, fatigue, swollen lymph glands or other symptoms of systemic illness? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Refer		
Is this a previous infection that did not fully clear despite proper treatment? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Refer		
Has one week of previous antifungal therapy yielded no improvement? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Refer		
Do the lesions exhibit any of these severe characteristics? <input type="checkbox"/> Extensive <input type="checkbox"/> On the penis, scrotum or vulva <input type="checkbox"/> Severely inflamed <input type="checkbox"/> Weeping or purulent <input type="checkbox"/> Painful <input type="checkbox"/> Disabling <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes → Refer		
Are symptoms consistent with diagnosis of tinea cruris? <input type="checkbox"/> Large round, red spots in groin area, with bumpy or scaly edges <input type="checkbox"/> Reddened areas can extend down inner leg or upwards to stomach or buttocks <input type="checkbox"/> Usually prominent itch <input type="checkbox"/> Predominately yes → Continue <input type="checkbox"/> 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 2 to 4 weeks.

Massage in gently.

Mitte: 30g

Prescription Issued for minor ailment

Rationale for prescribing:

Rx:

Quantity (7 days for terbinafine; 2-4 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:

Fax Number:

Pharmacist Minor Ailment Prescribing Record

To

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

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 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:
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