PHARMACIST ASSSESMENT – TINEA PEDIS (ATHLETE'S FOOT)

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

Does the patient have risk factors for tinea pedis?
- ☐ Prone to sweating feet / wears non-breathable socks or footwear
- ☐ Patient goes barefoot especially in swimming pools or public change rooms
- ☐ Other family members with current tinea pedis

☐ Yes to any → Supports patient's diagnosis

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

Has the patient tried any non-pharmacologic or pharmacologic treatment for tinea pedis?
☐ 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 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 (both top and bottom of foot)
- ☐ Toenails infected
- ☐ Severely inflamed
- ☐ Weeping or purulent
- ☐ Painful
- ☐ Disabling

☐ No → Continue ☐ Yes → Refer

Are symptoms consistent with diagnosis of tinea pedis?
- ☐ White fissures, scaling, or maceration between the toes
- ☐ Area is inflamed, blistered, itchy or burning
- ☐ Fissures or scaling between the toes

☐ 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 4 to 6 weeks.
Massage in gently.
Mitte: 30g

Prescription Issued for minor ailment

Rationale for prescribing:

Rx:

Quantity (7 days for terbinafine; 4-6 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

<table>
<tr><td colspan="3">To

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

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.</td></tr>
<tr><td colspan="3">Patient Demographics</td></tr>
<tr><td>Name:</td><td colspan="2">HSN:</td></tr>
<tr><td>Address:</td><td>DOB:</td><td>Gender: ☐ male ☐ female</td></tr>
<tr><td>Telephone:</td><td colspan="2">☐ Pregnant ☐ Lactating</td></tr>
<tr><td colspan="3">Prescription Issued on

MEDICATION:

DIRECTIONS:

QUANTITY:</td></tr>
<tr><td colspan="3">Rationale for prescription / relevant patient information</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">I will follow-up with the patient on and discuss these items:</td></tr>
<tr><td colspan="3">☐ If worsening or no improvement, refer
☐ If improving, encourage continued treatment for appropriate duration and for 1 week after symptoms resolve (unless using terbinafine)</td></tr>
<tr><td colspan="3">Prescribing Pharmacist</td></tr>
<tr><td>Name:</td><td colspan="2">Signature:</td></tr>
<tr><td>Pharmacy:</td><td colspan="2">Telephone:
Fax:</td></tr>
<tr><td>Email:</td><td colspan="2">Date:</td></tr>
<tr><td colspan="3">Primary Care Provider Notified</td></tr>
<tr><td>Name:</td><td colspan="2">Fax:</td></tr>
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