PHARMACIST ASSESSMENT - ALLERGIC RHINITIS

Patient	
Name	Sex: □ male □ female
Address:	DOB:
Telephone:	□ Pregnant □ Lactating
Medical History:	
Drug History/ Drug allergies:	

1. Patient History

Is the patient ≤ 2 years of age?
□ No --> Continue □ Yes --> Refer to MD

Is the patient pregnant?
□ No --> Continue □ Yes --> Refer to MD

Does the patient have asthma, recurrent or chronic sinusitis, otitis media?
□ No --> Continue □ Yes --> Refer to MD

Is the patient taking a medication suspected of causing the symptoms (ASA, NSAID, ACE-inhibitor, alpha blocker, beta blocker, etc.)?
□ No --> Continue □ Yes --> Recommend stopping or changing medication and / or refer to MD

2. Review of Symptoms

Does the patient have symptoms which suggest anaphylaxis?
□ No --> Continue □ Yes --> Medical help needed immediately

Does the patient have shortness of breath, persistent headache, eye pain?
□ No -->Continue □ Yes to any --> Refer to MD

Doe the patient have symptoms consistent with allergic rhinitis?
__ Sneezing
__ Rhinorrhea
__ Nasal congestion
__ Itchy eyes /throat
□ Yes --> Continue □ No --> Consider other conditions / refer to MD

Does the patient have symptoms primarily in one nostril?
□ No --> Continue □ Yes --> Refer to MD

How long have the symptoms been present?
□ 7 days or longer --> Continue □ Less than 7 days --> Consider upper respiratory tract infection

How severe are the symptoms?
Mild (able to perform normal activities and sleep normally)
□ Intermittent --> OTC treatment PRN
□ Frequent or persistent --> Consider prescription for intranasal corticosteroid

Moderate (symptoms interfere significantly with normal activities and/or sleep.)
□ Intermittent --> Consider prescription for intranasal corticosteroid
□ Persistent --> Refer to MD

3. Treatment

□ Nonpharmacological - allergen /irritant avoidance
□ OTC - antihistamine, oral decongestant PRN for **mild, infrequent symptoms**
□ Intranasal corticosteroid for **frequent or persistent mild symptoms** or **intermittent moderate symptoms**

4. Prescription Issued

Rationale for prescribing: Minor ailment
Any other relevant information:

Rx: (Name. strength)

Quantity:

Dosage Directions:

5. Counseling

□ Instructions on use of intranasal inhaler
□ Expect relief of symptoms in 1 to 2 days; may take up to 2 weeks for maximum effect; if no response in 48 hours or symptoms worsen, contact your pharmacist or MD
□ Allergen avoidance

6. Follow-up scheduled in 2 - 4 weeks (date):

□ In pharmacy □ Telephone (number:_____)
□ Symptoms resolved
□ Symptoms improved but requires continuing therapy --> Contact / refer to MD
□ Symptoms not improved --> Refer to MD

Prescribing Pharmacist:

Name:

Pharmacy:

Tel: Fax: Email:

Signature	Date: