PHARMACIST ASSESSMENT – UNCOMPLICATED URINARY TRACT INFECTION

Patient	
Name:	HSN:
Address:	DOB:
Telephone:	¨ Pregnant à Refer to MD ¨ lactating

Medical History: ¨ Renal Dysfunction: CrCl = _____

Previous episode(s) of UTI diagnosed?
¨ Yes à Continue ¨ No à Refer

Previous episode of UTI within last 4 weeks?
¨ Yes à Refer ¨ No à Continue

Two or more episodes of UTI within last 6 months or three or more episodes within last 12 months?
¨ Yes à Refer for consideration of prophylaxis +/- continue assessment for treatment

Does the patient have an immunocompromising condition (including poorly controlled diabetes)?
¨ Yes à Refer

Does the patient have abnormal urinary tract function or structure?(indwelling catheter, neurogenic bladder, renal stones, renal dysfunction, etc.)
¨ Yes à Refer

Is the patient male or <16 years of age? ☐ Yes à Refer ☐ No à Continue

Drug History/Drug Allergies:

Does the patient take a medication which suppresses the immune system? (See guideline)
¨ Yes à Refer

Does the patient take a medication which can cause cystitis? (Cyclophosphamide, allopurinol, danazol, or tiaprofenic acid)
¨ Yes à Consider discontinuation, alternatives and/ or refer

Prior treatment for UTI:
Medication:
Effect:
Tolerance:

Review of Symptoms

Does the patient have two or more of **:**
¨ Dysuria ¨ Frequency / Urgency ¨ Suprapubic discomfort AND ¨ No vaginal symptoms

¨ Yes à Continue ¨ No à Refer for further investigation

Are any signs of pyelonephritis present?
¨ Fever ¨ Chills ¨ Nausea and vomiting ¨ Flank or back pain ¨ Significant malaise

¨ No à Continue ¨ Yes à Refer

Are any other unusual symptoms present?

¨ Vaginal discharge or itch ¨ Dyspareunia ¨ Other significant symptoms

¨ No à Continue ¨ Yes à Consider alternate diagnosis / refer

Treatment: (if pediatric patient, see guideline for treatment options)

First Line:

¨ Nitrofurantoin (Macrobid) 100mg PO BID x 5 days

Second Line:

¨ Sulfamethoxazole-trimethoprim 800mg / 160mg PO BID x 3 days (Avoid if used in the previous 3 months)

Or

¨ Trimethoprim 100mg PO BID x 3 days

Or

¨ Trimethoprim 200mg PO OD x 3 days

Or

¨ Fosfomycin 3g dissolved in ½ cup of cold water OD x 1 day (not indicated if <18 years old)

Prescription Issued for minor ailment

Rationale for prescribing:

Rx:

Quantity (enough for one course of treatment only):

Directions:

¨ May have prescription filled at pharmacy of choice ¨ PAR will be communicated to primary care provider as part of collaborative practice

pseudoDIN 00951103

Follow up scheduled in 3 days:

¨ Assess for significant improvement in all symptoms
¨ Determine if side effects are occurring (esp. severe diarrhea or rash)
¨ If worsening or not improving, refer to MD
¨ If improving, encourage continued use until the end of therapy if greater than 3 days

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 a **recurrent, uncomplicated urinary tract infection.** The patient has had this issue previously diagnosed. 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:
Telephone:	□ Pregnant □ Breastfeeding

Prescription Issued on _____

MEDICATION:

DIRECTIONS:

QUANTITY:

Rationale for prescription / relevant patient information:

I will follow-up with the patient on _____ and discuss these items:

¨ Assess for significant improvement in all symptoms
¨ Determine if side effects are occurring (esp. severe diarrhea or rash)
¨ If worsening or not improving, refer to MD
¨ If improving, encourage continued use until the end of therapy if greater than 3 days

Prescribing Pharmacist:

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

Primary Care Provider notified:

Name:	Fax: