medSask
YOUR MEDICATION INFORMATION SERVICE

PHARMACY ASSOCIATION OF SASKATCHEWAN

Injectable Drug (non-vaccine) Screening Tool and Consent Form

Patient information	
Name: (Last, First)	Date of birth (DD-MM-YYYY):
Address:	
Health Services Number:	Gender: M / F Weight:
Daytime Phone Number:	Alternate Phone Number:
Emergency Contact Information Name:	Phone Number:
For Women Pregnant: ☐ Yes ☐ No ☐ N/A	Breastfeeding: ☐ Yes ☐ No ☐ N/A

Screening: The following questions will help determine if this injectable drug is right for you (or your child/dependent) today. A "yes" to any question does not necessarily mean you should not receive the injection but your pharmacist should be aware of this information and may have some additional questions for you.

Please answer the following questions:

Question	Yes	No
1. Do you (or your child/dependent) feel sick today?	☐ Yes	☐ No
2. Do you (or your child/dependent) have allergies to medications, food or latex?	☐ Yes	☐ No
3. Have you (or your child/dependent) had a history of a serious reaction after receiving an injection in the past?	☐ Yes	☐ No
4. Have you (or your child/dependent) experienced a change in health status that your pharmacist may not be aware of?	☐ Yes	☐ No

Declaration of Consent:

I confirm that I have read or had explained to me the risks, benefits and potential side effects associated with ___________________________ (drug name). My questions have been answered by the pharmacist and I am satisfied with and understand the information I have been given. I consent to receiving or my child /dependent receiving this injection, and understand the requirement for post-injection observation by the pharmacist for 15 minutes.

____ ______________________________

Signature of: ☐ Injection recipient ☐ Parent /guardian Date

For Pharmacist Use Only

Drug: Name, DIN, Lot #, Expiry Date	Dose	Site	Route	Dose #	Pharmacist Signature	Date &Time of Injection
		LA RA Other:	IM SC ID			

Adverse reaction: ☐ No ☐ Yes – describe reaction: Price, if applicable:

☐ Notified primary care practitioner (if applicable) Name: _________________________________ Fax #:_________________________

**Please refer to product monograph for screening question support and administration instructions.*
Ensure patient medication profile checked prior to injection.