PHARMACIST ASSESSMENT – HEADACHE AND MIGRAINE

Patient		
Name:	HSN:	
Address:	DOB:	Gender: ☐ male ☐ female
Telephone:	☐ Pregnant ☐ Lactating	

Medical History: ☐ Renal dysfunction ☐ Hepatic dysfunction ☐ Cardiovascular or cerebrovascular disease

Drug History/ Drug allergies:

Patient History

Is the patient over 50 years old and this is a new, undiagnosed headache?
☐ No à Continue ☐ Yes à Refer

Is this the patient's first or worst headache?
☐ No à Continue ☐ Yes à Refer (refer to emergency if worst headache)

Does the patient experience 6 or more headaches per month or significant impairment of quality of life due to headaches?
☐ No à Continue ☐ Yes à Refer for prophylactic therapy, but may still prescribe treatment in interim

Has the patient had any recent head trauma?
☐ No à Continue ☐ Yes à Refer to emergency room

Does the patient have uncontrolled hypertension?
☐ No à Continue ☐ Yes à Refer

Is the patient on any medications which can cause headaches, or suffering from a medication withdrawal?
☐ No à Continue ☐ Yes à Refer to care provider, or contact to suggest management strategies

Has the patient previously had their headache diagnosed by a primary care provider (helps self-diagnosis and EDS)?
☐ Yes à tension headache ☐ Yes à migraine ☐ No à continue

Has the patient tried any non-pharmacologic or pharmacologic treatment for their headache?
☐ No à Continue ☐ Yes → What*? Effect?
*Triptan use within 12h of ergotamines (or 24h if naratriptan to be used) is contraindicated

Has the patient used any headache treatment for more than 10-15 days per month for 3 or more months?
☐ No à Continue ☐ Yes à Suspect medication overuse headache and refer, or contact care provider to suggest management strategies

Does the patient have a history of, or risk factors for, cardiovascular or cerebrovascular disease? (see full treatment guidelines for definition of CVD and risk factors)
☐ No à Continue ☐ Yes à Prefer treatment options other than NSAIDs; triptans contraindicated; consider referral

Review of Symptoms

Is the patient experiencing impairment of speech, sensation, strength or consciousness?
☐ No à Continue ☐ Yes à Refer to emergency room

Is the patient experiencing a concurrent fever with neck stiffness?
☐ No à Continue ☐ Yes à Refer to emergency room

Does the patient have unilateral eye pain, red eye, fixed and dilated pupil?
☐ No à Continue ☐ Yes à Refer to emergency room

Is this headache different (pattern, symptoms, severity) than previous headaches?
☐ No à Continue ☐ Yes à Refer to emergency room

Does the headache occur with exercise or sexual activity?

☐ No à Continue ☐ Yes à Refer

Is the pain greater than 6 on a scale of one to ten?

☐ No à Continue ☐ Yes à Consider referral

Are the symptoms consistent with a **migraine?**

Two or more of the following:

☐ Throbbing or pulsating pain ☐ Aggravated by activity ☐ Unilateral pain ☐ Lasts 4-72 hours

PLUS one of:

☐ Nausea ☐ Vomiting ☐ Photophobia ☐ Phonophobia

☐ No à Continue ☐ Yes à proceed to treatment

Are the symptoms consistent with a **tension** headache (two or more of the following)?

☐ Bilateral headache ☐ Mild-moderate intensity

☐ Non-pulsating pain (pressing / tightening pain) ☐ Not worsened by activity

☐ Yes à proceed to treatment ☐ No à diagnosis unsure, refer

Treatment recommended

☐ Suggest non-pharmacologic measures

☐ Mild tension headache or migraine: OTC doses of analgesics (acetaminophen or NSAIDs)

☐ Moderate tension headache or mild tension headache not relieved by optimal OTC measures already tried: Prescription dose of an NSAID

☐ Moderate migraine or mild migraine not relieved by optimal OTC measures already tried: Prescription dose NSAIDs or a triptan (see guideline for list of eligible products)

☐ If more than 8 headaches per month, strongly consider referral to prescriber for prophylactic therapy

Prescription Issued for minor ailment

Rationale for prescribing:

Rx:

Quantity (may prescribe enough to treat up to 4 headaches / migraines per prescription):

Directions:

pseudoDIN: 00951097

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

☐ Non-pharmacologic management

☐ Optimal administration of medications (eg. loading dose for NSAIDs, triptan use and timing if aura present)

☐ Headache should be aborted within 2 to 6 hours

☐ Avoidance of medication overuse headaches

☐ Side effects of chosen treatment

☐ When initiating prophylactic therapy may be appropriate

☐ Keep a headache diary to detail number of headaches per month, triggers, and effectiveness of treatment

Follow-up scheduled on ☐ **In pharmacy** ☐ **By telephone**

☐ If possible, follow up within 24 hours to see if headache aborted

☐ Ask about side effects of medications

☐ Monitor for medication overuse headache at following visits

☐ If no improvement, try alternate option for future episode. Refer if two trials fail to provide improvement

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 **primary headache.**

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: ☐ male ☐ female
Telephone:	☐ Pregnant ☐ 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 possible, follow up within 24 hours to see if headache aborted
☐ Ask about side effects of medications
☐ Monitor for medication overuse headache at following visits
☐ If no improvement, try alternate option for future episode. Refer if two trials fail to provide improvement

Prescribing Pharmacist	
Name:	Signature:
Pharmacy:	Telephone: Fax:
Email:	Date:
Primary Care Provider Notified	
Name:	Fax: