

PHARMACIST ASSESSMENT – SHINGLES

Patient		
Name:	HSN:	
Address:	DOB:	Gender: <input type="checkbox"/> male <input type="checkbox"/> female
Telephone:	<input type="checkbox"/> Pregnant → Refer <input type="checkbox"/> Lactating	
Medical History: Immunosuppression due to disease (HIV, malignancies, uncontrolled diabetes, etc.) <input type="checkbox"/> Yes → Refer, consider initiating a prescription for an oral antiviral <input type="checkbox"/> No → Continue <input type="checkbox"/> Renal dysfunction If yes, CrCl = ____ (Adjust dose of antiviral doses as recommended in guidelines)		
Drug History: Immunosuppression due to medication (e.g., high dose corticosteroid, chemotherapy, certain biologicals) <input type="checkbox"/> Yes → Refer, consider initiating a prescription for an oral antiviral <input type="checkbox"/> No → Continue Recently started new medication <input type="checkbox"/> Yes → Rule out drug-induced rash before continuing <input type="checkbox"/> No → Continue		
Review of Symptoms		
Signs / Symptoms typical of shingles: <input type="checkbox"/> Rash which follows dermatomes (unilateral, usually does not cross midline) <input type="checkbox"/> Rash consists of macules or papules, some may have progressed into vesicles or pustules <input type="checkbox"/> Pain predominately in and around area of rash (possibly some pruritus) <input type="checkbox"/> Prodromal stage of pain, burning, tingling or numbness preceding the rash (not always present) <input type="checkbox"/> Mostly yes → Continue <input type="checkbox"/> No → Consider alternate diagnosis and/or refer Age < 50 years: <input type="checkbox"/> Yes → Benefit of antivirals unproven in uncomplicated, otherwise healthy person <input type="checkbox"/> Recommend non-pharmacological, OTC treatment for symptoms <input type="checkbox"/> Can consider antiviral treatment if patient requests it Signs / Symptoms of complicated, severe shingles: <input type="checkbox"/> Neurologic changes (eg. confusion or delirium) <input type="checkbox"/> Systemic symptoms (e.g. nausea, vomiting, high fever, or other signs of systemic infection or disorder) <input type="checkbox"/> Ocular involvement (e.g. vesicles at tip of nose, blurred vision, eye pain) <input type="checkbox"/> Auricular involvement (e.g. vesicles around or in ear, impaired hearing, vertigo) <input type="checkbox"/> Pain > 7 out of 10 <input type="checkbox"/> Yes to any → Refer, consider initiating a prescription for an oral antiviral Has the rash been present for more than 72 hours? <input type="checkbox"/> No → Continue <input type="checkbox"/> Yes <input type="checkbox"/> Uncomplicated → Non-pharmacologic treatment of lesions, OTC analgesics, refer if pain is severe <input type="checkbox"/> Complicated symptoms or immunocompromised patient → Refer but <u>consider</u> prescribing antiviral if patient does not have immediate access to medical care		

Treatment recommended

- ☐ Initiate non-pharmacologic therapy
- ☐ Mild to moderate pain: OTC analgesics
- ☐ Antiviral therapy for 7 days*:
 - ☐ Acyclovir** 800mg five times daily
 - ☐ Famciclovir 500mg three times daily
 - ☐ Valacyclovir 1000mg three times daily

****Dosage adjustments required with impaired renal function. See guideline for details.***

*****Acyclovir only indicated in pediatric population. Age ≥ 12 : 800mg five times daily***

Prescription Issued

Rationale for prescribing:

Rx:

Quantity (provide 7 day supply, no refills):

Directions:

pseudoDIN 00951323

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
- ☐ Expectations of antiviral therapy (eg, rash resolution, level of pain reduction)
- ☐ If no response or symptoms worsening (new vesicles, symptoms of bacterial superinfection), contact pharmacist, MD or NP

Follow-up scheduled in 7 days:

- ☐ In pharmacy ☐ Telephone
- ☐ Adequate pain control achieved
- ☐ Rash symptoms resolving (no new vesicle formation; majority of blisters scabbed over)
 - ☐ No to either → Refer
- ☐ Discussion about post-herpetic neuralgia
 - ☐ Instruct patient to report to pharmacist or doctor if pain persists or worsens

Prescribing Pharmacist:

Name:	Signature:
Pharmacy:	Telephone:
	Fax:
Email:	Date:
Primary Care Provider:	Fax #:

Pharmacist Minor Ailment Prescribing Record

To

This document is to inform you I met with your patient below who presented with self-diagnosed **shingles**. 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:	<input type="checkbox"/> male	<input type="checkbox"/> female
Telephone:	<input type="checkbox"/> Pregnant <input type="checkbox"/> 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:

- ☐ Adequate pain control achieved
- ☐ Rash symptoms resolving (no new vesicle formation; majority of blisters scabbed over)
 - ☐ No to either → Refer
- ☐ Discussion about post-herpetic neuralgia
- ☐ Instruct patient to report to pharmacist or doctor if pain persists or worsens

Prescribing Pharmacist:

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

Primary Care Provider notified:

Name:	Fax:
-------	------