medSask
YOUR MEDICATION INFORMATION SERVICE

PHARMACIST ASSSESMENT – TINEA PEDIS (ATHLETE'S FOOT)

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

Medical History:

☐ Diabetic → refer

☐ Immunocompromised (disease or drug-induced) → refer

☐ Previous diagnosis of tinea pediss → helps confirm patient self-diagnosis

Drug History:

Review of Symptoms

Any red flags present?

- ☐ Fever, fatigue, swollen lymph glands or other symptoms of systemic illness
- ☐ This may be a previous infection that did not fully clear, despite proper treatment
- ☐ One week of previous antifungal therapy has yielded no improvement
- ☐ Lesions exhibit any severe characteristics:
  - ☐ Extensive (both top and bottom of foot)
  - ☐ Toenails infected
  - ☐ Severely inflamed
  - ☐ Weeping or purulent
  - ☐ Painful
  - ☐ Disabling

☐ Yes → refer

Does the patient have risk factors for tinea pedis?

- ☐ Prone to sweating feet / wears non-breathable socks or footwear
- ☐ Patient goes barefoot especially in swimming pools or public change rooms
- ☐ Other family members with current tinea pedis

☐ Yes → helps confirm patient self-diagnosis

Are symptoms consistent with diagnosis of tinea pedis?

- ☐ White fissures, scaling, or maceration between the toes
- ☐ Area is inflamed, blistered, itchy or burning
- ☐ Fissures or scaling between the toes

☐ Predominately yes → Continue ☐ No → consider other conditions / refer

Has the patient tried any non-pharmacologic or pharmacologic treatment for tinea pedis?

☐ No ☐ Yes → What? Effect?

Treatment

☐ Non-pharmacologic treatment measures

☐ OTC topical - clotrimazole, miconazole, or tolnaftate BID for 4 weeks

☐ Prescription antifungal (slightly more effective / more rapid acting)

Options:

☐ **Terbinafine 1% Cream** (children ≥12 and adults)
Apply adequate amount of cream to cover affected area and approximately 2cm beyond visible edge of lesions ONCE daily for 7 days.
Massage in gently.
Mitte: 30g

☐ **Terbinafine 1% Spray** (children ≥12 and adults)
Spray sufficient amount of solution to cover treatment area and surrounding skin ONCE daily for 7 days.
Mitte: 30ml

☐ **Ketoconazole 2% Cream**
Apply adequate amount of cream to affected area and approximately 2cm beyond visible edge of lesions ONCE daily for 4 to 6 weeks.
Massage in gently.
Mitte: 30g

Prescription Issued for minor ailment

Rationale for prescribing:

Rx:

Quantity (7 days for terbinafine; 4-6 weeks for ketoconazole):

Directions:

pseudoDIN: 00951101

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

☐ Adjunctive measures to ensure positive outcomes
☐ Duration of therapy (and to extend 1 week after symptoms resolve unless using terbinafine)
☐ Appropriate application area
☐ If no improvement after 1 week of pharmacologic treatment, or if symptoms worsen, refer

Follow-up scheduled in 7 days:

☐ In pharmacy ☐ Telephone
☐ If worsening or no improvement, refer
☐ If improving, encourage continued treatment for appropriate duration and for 1 week after symptoms resolve (unless using terbinafine)

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 **a tinea pedis.**

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 worsening or no improvement, refer

☐ If improving, encourage continued treatment for appropriate duration and for 1 week after symptoms resolve
(unless using terbinafine)

Prescribing Pharmacist	
Name:	Signature:
Pharmacy:	Telephone: Fax:
Email:	Date:
Primary care provider notified	
Name:	Fax: