medSask
YOUR MEDICATION INFORMATION SERVICE

PHARMACIST ASSESSMENT - ALLERGIC RHINITIS

Patient Information		
Name:	HSN:	
Address:	DOB: (≤2 → refer)	☐ male ☐ female
Telephone:	☐ Pregnant (refer if pregnant) ☐ Lactating	

Medical History:

☐ Asthma, recurrent or chronic sinusitis, otitis media → refer

☐ Previous diagnosis of allergic rhinitis → helps confirm patient diagnosis

Drug History:

☐ Medication suspected of causing symptoms (ASA, NSAID, ACE-inhibitor, α-blocker, β-blocker) → d/c or change medication or refer

Review of Symptoms

Any of the following red flags present?

☐ Symptoms which suggest anaphylaxis

☐ Shortness of breath, persistent headache, eye pain

☐ Symptoms primarily in one nostril

☐ Duration of symptoms less than 7 days (consider potential upper respiratory tract infection)

☐ Yes → refer (emergency referral if anaphylaxis)

Symptoms consistent with allergic rhinitis?

☐ Sneezing

☐ Rhinorrhea

☐ Nasal congestion

☐ Itchy eyes /throat

☐ Yes → Continue ☐ No → Consider other conditions / refer

Severity of symptoms?

Mild (able to perform normal activities and sleep normally)

☐ Intermittent→ antihistamine or oral decongestant prn

☐ Frequent or persistent → Consider intranasal corticosteroid

Moderate to Severe (symptoms interfere significantly with normal activities and/or sleep)

☐ Intermittent → Consider intranasal corticosteroid

☐ Persistent → Refer

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

☐ No ☐ Yes → What was tried?

What was the effect?

Treatment

☐ Non-pharmacologic: allergen / irritant avoidance

☐ OTC: antihistamine, oral decongestant for **mild, infrequent symptoms**

☐ Intranasal corticosteroid for **mild, frequent or persistent** or **moderate, intermittent symptoms**

Prescription Issued for minor ailment

Rationale for prescribing:

Rx:

Quantity (may provide enough for patient's allergy season):

Dosage Directions:

pseudoDIN: 00951090

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

☐ Instructions on use of intranasal inhaler

☐ Expect relief of symptoms in 1 to 2 days; may take up to 2 weeks for maximum effect; if no response in 48 hours or symptoms worsen, contact your pharmacist or primary care provider

☐ Allergen avoidance

Follow-up scheduled in 2 - 4 weeks (date):

☐ In pharmacy ☐ Telephone

☐ Symptoms resolved

☐ Symptoms improved, but require chronic therapy longer than allergy season --> contact primary care provider

☐ Symptoms not improved → Refer

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 **allergic rhinitis.**

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:	□ male □ female
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:

☐ Symptoms resolved
☐ Symptoms improved, but require chronic therapy longer than allergy season → Contact primary care provider
☐ Symptoms not improved → Refer

Prescribing pharmacist

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

Primary care provider notified

Name:	Fax: