PHARMACIST ASSESSMENT – ATOPIC DERMATITIS

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

Medical History:

☐ Family history of atopic dermatitis or previous diagnosis with atopic dermatitis → helps confirm condition

Drug History / Drug allergies:

☐ Any recent drug changes → consider symptoms as a possible adverse drug reaction

☐ Recent sun exposure while taking a photosensitizing drug → recommend changing medication, and/or refer

Review of Symptoms

Any of the following red flags present?

- ☐ Large areas of skin involved (more than 30% of surface area)
- ☐ Moderate or severe lesions on face
- ☐ Signs or symptoms of an infection
- ☐ Recent contact with unknown plant or exposure to chemicals
- ☐ Recent contact with person with similar skin condition (consider other conditions, eg scabies, pediculosis)

☐ Yes → refer

Signs and symptoms consistent with atopic dermatitis?

- ☐ dry skin
- ☐ pruritus
- ☐ patches of redness, scaling, excoriations (scratches)
- ☐ weeping, crusting vesicles
- ☐ None of the above → Consider other conditions / refer

Location of the lesion(s):

*Helps determine steroid potency to use (see treatment section)

Has any pharmacologic or non-pharmacologic treatment been used for symptoms?

☐ No ☐ Yes → What was tried?

What was the effect?

Treatment

☐ Non-pharmacologic: general measures, emollients, moisturizers combined with steroid options below

☐ OTC: hydrocortisone 0.5 to 1%* cream or ointment, or Spectro Eczema Care® 0.05%

*Hydrocortisone 1% is prescription only if under 2 years old

☐ **Low or medium potency topical corticosteroid** (See guideline for list of options)

- **Infant:** all areas → prescribe low potency corticosteroid
- **Older child, adult:** face, skin folds → prescribe low potency corticosteroid
- **Older child, adult:** body, limbs, scalp → prescribe low to moderate potency corticosteroid

Prescription Issued

Rationale for prescribing:

Rx (Name, strength, form):

Quantity (amount for 7 days, with one refill):

Dosage Directions:

pseudoDIN: 00951094

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

☐ Instructions on general measures, trigger avoidance

☐ Expect relief of symptoms within 7 days; if no response or symptoms worsen, contact your pharmacist or care provider

☐ Continue corticosteroid use for 48 hours after symptoms resolve; if using moderate potency product, step down to low potency for a few days

Follow-up scheduled in 7 days (date):

☐ In pharmacy ☐ Telephone

☐ Symptoms resolved → stop corticosteroid treatment, continue regular use of emollients

☐ Symptoms improving → counsel to continue corticosteroid treatment for up to another 7 days. If symptoms are not resolved within 14 days treatment contact your primary care provider

☐ Symptoms not improved or new lesions have appeared → Refer

☐ Tolerability issues with chosen formulation (eg. too greasy or irritating leading to non-adherence) → initiate more acceptable formulation for another 7 days and repeat follow-up

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 **atopic dermatitis.**

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 → stop corticosteroid treatment; continue regular use of emollients
☐ Symptoms improving → counsel to continue corticosteroid treatment for up to another 7 days. If symptoms are not resolved within 14 days treatment contact primary care provider
☐ Symptoms not improved or new lesions have appeared → Refer
☐ Tolerability issues with chosen formulation (eg. too greasy or irritating leading to non-adherence) → initiate more acceptable formulation for another 7 days and repeat follow-up

Prescribing Pharmacist

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

Primary Care Provider notified

Name:	Fax: