**PHARMACIST ASSESSMENT – MUSCULOSKELETAL PAIN**

**Patient**

| | | |
|---|---|---|
| Name: | HSN: | |
| Address: | DOB: (<2 → refer) | ☐ male ☐ female |
| Telephone: | ☐ Pregnant (No NSAIDs if planning or 3rd trimester) ☐ Lactating | |

**Medical History:**

☐ Renal dysfunction → caution with NSAIDs if severe

☐ Osteoarthritis → refer if pain is primarily in joints

☐ History of, or risk factors for, cardiovascular or cerebrovascular disease (*see treatment guidelines for definition of CVD and risk factors)* → prefer treatment options other than NSAIDs (esp. diclofenac); refer if NSAID is necessary

**Drug History:**

☐ Statin use → consider possible statin-induced myopathy as a cause of symptoms

**Review of Symptoms**

**Any of the following red flags present?**

☐ Visible joint changes, abnormal movement, weakness in any limb, or suspected fracture

☐ Pelvic or abdominal pain (other than dysmenorrhea)

☐ Accompanying nausea, vomiting, fever, or other signs of systemic infection or disorder

☐ Pain present for more than 2 weeks (or >7 days with treatment), without improvement

☐ Pain is moderate to severe (≥6 on pain scale or impact on daily life) or increased intensity

☐ Yes → refer

**Does the patient attribute the pain to overexertion or muscle or joint injury?**

☐ Yes → self-care appropriate, proceed to treatment ☐ No → refer

**Has the patient tried any non-pharmacologic or pharmacologic treatment for their pain?**

☐ No ☐ Yes → What? Effect?

**Treatment recommended**

☐ Initiate RICE (if within 3 days since injury)

☐ Mild pain: OTC analgesics (topical or oral) and / or muscle relaxants for 7 days

☐ Moderate pain: Prescription NSAID for pain and stiffness for 7 days, refill X 1 PRN

**Prescription Issued for minor ailment**

Rationale for prescribing:

Rx:

Quantity (provide 7 days worth, may refill once – up to 14 days therapy total):

Directions:

pseuoDIN: 00951099

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

☐ RICE therapy
☐ Expect onset of effect in 15 to 30 minutes
☐ If no response or symptoms worsen, contact your pharmacist or primary care provider

**Follow-up scheduled in 7 days:**

☐ In pharmacy ☐ Telephone
☐ Symptoms improved or resolved: continue therapy for a maximum of 14 days in total; discontinue medication once symptoms have resolved
☐ Symptoms not improving: refer
☐ Intolerable side-effects to medication: recommend different drug, assess administration (eg. with food), refer

**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 **acute musculoskeletal pain.**

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:**

☐ Symptoms improved or resolved: continue therapy for a maximum of 14 days in total; discontinue medication once symptoms have resolved

☐ Symptoms not improving: refer

☐ Intolerable side-effects to medication: recommend different drug, assess administration (eg. with food), refer

| **Prescribing Pharmacist** | |
|---|---|
| Name: | Signature: |
| Pharmacy: | Telephone:<br>Fax: |
| Email: | Date: |
| **Primary care provider notified** | |
| Name: | Fax: |