PHARMACIST ASSESSMENT RECORD – Hormonal Contraceptive

Patient			
Name:	HSN:	Height: Weight:	BMI:
Address:	DOB: (Age <12 – refer)		
Telephone:	☐ Lactating ☐ < 6 wks postpartum ☐ < 6 mon postpartum		

Drug History

- ☐ Antibiotics (rifampin)
- ☐ Antiepileptics (lamotrigine, carbamazepine, phenobarbital, phenytoin, topiramate, primidone, oxcarbazepine)
- ☐ Antiretrovirals (ritonavir, efavirenz, nevirapine)
- ☐ St. John's wort
  - ☐ Yes to any → Decreased OC effect, discuss non-hormonal contraception +/- refer
- ☐ Other relevant medications:

Medical History

Does the patient have any of the following contraindications to hormonal oral contraceptives:

- ☐ Current or past history of breast cancer
- ☐ Active liver disease, cirrhosis, hepatic tumour
  - ☐ Yes to any → Not a candidate for hormonal contraception, discuss nonhormonal options and/or refer
  - ☐ No → Continue

Does the patient have any of the following contraindications to estrogen-containing contraceptives:

- ☐ Current or history of MI, ischemic heart disease, valvular heart disease
- ☐ Current or history of VTE (DVT or PE)
- ☐ History of cerebrovascular disease (stroke)
- ☐ Thrombophilia (condition which causes hypercoagulable state eg. Factor V Leiden disorder)
- ☐ Current or past history of breast cancer
- ☐ Diabetes with microvascular complications (retinopathy, neuropathy, nephropathy, etc.)
- ☐ History of migraines with aura at any age
- ☐ History of migraines without aura if over 35 years old
- ☐ History of hypertension
- ☐ Active systemic lupus erythematosus with antiphospholipid antibodies
- ☐ Uncontrolled inflammatory bowel disease
- ☐ Smokes $\geq$15 cigarettes/day AND is over 35 years old?
- ☐ Less than 6 weeks postpartum (absolute CI); less than 6 months (relative CI)
  - ☐ Yes to any → Not a candidate for COCs, consider POC, nonhormonal options and/or refer
  - ☐ No → Continue

Does the patient have two or more of the following risk factors:

- ☐ Age over 40 years
- ☐ Obesity (BMI >30kg/m^2)
- ☐ Smoker (any amount) and under 35 years old
- ☐ Diabetes (controlled)
- ☐ Dyslipidemia
- ☐ Migraine without aura and under 35 years old
  - ☐ Yes to $\geq$2 risk factors → COCs may not be the best option, consider POC or non-hormonal method, and/or refer
  - ☐ No → Continue

Patient information

Is there a chance the patient could be pregnant?

☐ No → Continue ☐Yes → Rule out pregnancy before proceeding (pregnancy test or refer)

Would the patient like to become pregnant within the next year?

☐ Yes → Continue ☐ No → Discuss LARCs, refer if preferred

Does the patient have signs or symptoms of an untreated medical condition?

☐ Undiagnosed vaginal bleeding ☐ Other signs / symptoms of concern:

☐ None → Continue ☐ Yes → Refer

Blood pressure:

☐ > 140/90 → Refer ☐ ≤ 140/90 → Continue

Treatment recommended

☐ Combined oral contraceptive
☐ Progestin-only contraceptive
☐ Transdermal combined hormonal contraceptive
☐ Intravaginal combined hormonal contraceptive

*See guideline for available products and guidance on choosing therapy

Prescription Issued for minor ailment

Rationale for prescribing:

Rx:

Quantity (provide two month supply, 6 refills):

Directions:

pseudoDIN 00951104

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

☐ Start date and when protection begins
☐ What to do about missed doses
☐ Side-effect advice and management strategies
☐ STI prevention and safe sex practice

Follow up scheduled in 1 month:

☐ Assess for adverse effects; if very bothersome, can prescribe a different product or refer (Maximum of two trials before referring)
☐ Check adherence and knowledge about missed dose management
☐ Check for any changes in medical or medication history

Prescribing Pharmacist:

Name:	Signature:
Pharmacy:	Telephone:
	Fax:
Email:	Date:
Primary Care Practitioner:	**Fax Number:**

Pharmacist Minor Ailment Prescribing Record

To

This document is to inform you I met with your patient below who presented with a request for **hormonal contraception**. 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:	Height: Weight: BMI:
Address:	DOB:	
Telephone:	☐ Lactating ☐ < 6 weeks postpartum ☐ < 6 months postpartum	

Prescription Issued on _____

MEDICATION:

DIRECTIONS:

QUANTITY:

Rationale for prescription / relevant patient information:

Prescribing Pharmacist:

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

Primary Care Practitioner notified:

Name:	Fax: