The macro's used are named as you see with "___"… to access in a visit, go to a blank spot in your SOAP note… press Ctrl arrow down and anything with "assessment" at the end of the name is something that has been added by PANS

Advanced Medication Review "amrassessment"

-Patient intake form should be completed and reviewed before starting the service Y:

- Verbal consent to Provide the Service has been Provided by the Patient. For minors, the pharmacist has assessed that the patient is able to understand nature and/or Consent provided by Patient's Agent (if patient is not a mature minor). Y/N:
-Pt has been provided information about the AMR, and understand the program and consent to having the pharmacist conduct the review and understands that the pharmacist will share any findings with my primary care provider. Y/N:
-An AMR and BMR can not be billed on the same day. 1 med review service (BMR or AMR) is covered upon admission to a LTC facility.

Setting

-in person Y/N:

-virtual Y/N: See Pharmacare guide for specific criteria to be eligible for virtual med review.

Page 35 at https://novascotia.ca/dhw/pharmacare/documents/Pharmacy-Guide.pdf

If Yes, pt was eligible for a virtual AMR because:

-by phone. If yes, why not in person/virtual? Y/N:

-pt has brought in all their medications with them and pharmacist was able to visually verify each, Y/N:

If no, document why:

Criteria:

-patient is on 4 or more meds Y/N:

-or patient is on one of the following (indomethacin, methyldopa, diazepam, cyclobenzaprine, clorazepate, chlordiazepoxide, amitriptyline) Y/N:

AND -pt has a chronic disease (asthma, COPD, DM, HTN, hyperlipidemia, arthritis, congestive heart failure) Y:

AND -pt is 65+ and has NS Pharmacare Y/N:

OR (one of the following)

-pt has been referred for a medication assessment by a physician, NP, or NSH primary care site manager. Referral may also be by another pharmacist but only for unattached patients and if the needs of the patient are outside the expected scope of the referring pharmacist. Y/N:

-unattached pt with a significant unaddressed healthcare need that could benefit from a comprehensive medication review. Y/N:

-unattached pt with complex medical issues and medications, history of lack of consistent monitoring or follow up regarding medication management and could benefit from a comprehensive medication review to identify any drug related problems. Y/N

Explain:

Subjective/Objective

What concerns does the patient have with current medications:

To what extent does the patient understand his/her mediations, what do they expect from drug therapy:

Review of Patient Intake Form

Any Allergies to note:

Key findings from a review of lab values (if available):

Immunization. Any recommendations?

Key findings of Medical Conditions:

Key findings from Medication Adherence questions:

Key findings from Health and Lifestyle:

Review of Current Medications:

Today's Health (if applicable)

Blood pressure:

Weight:

Blood glucose:

Assessment/Plan

General Issues:

Recommended pharmacist changes by condition (only if there are DTPs and changes are required)

DTP condition 1

-Assessment condition (include signs/symptoms, current therapy, relevant lab data):

-Drug therapy problem classification (unnecessary therapy, needs additional therapy, different drug required, dose too low, dose too high, adhere, adverse drug reaction, no DTP):

-Monitoring (safety, efficacy, required lab work):

-Recommended Follow up:

DTP condition 2

-Assessment condition (include signs/symptoms, current therapy, relevant lab data):

-Drug therapy problem classification (unnecessary therapy, needs additional therapy, different drug required, dose too low, dose too high, adhere, adverse drug reaction, no DTP):

-Monitoring (safety, efficacy, required lab work):

-Recommended Follow up:

DTP condition 3

-Assessment condition (include signs/symptoms, current therapy, relevant lab data):

-Drug therapy problem classification (unnecessary therapy, needs additional therapy, different drug required, dose too low, dose too high, adhere, adverse drug reaction, no DTP):

-Monitoring (safety, efficacy, required lab work):

-Recommended Follow up:

Referral: patient is experiencing drug therapy problems that are not within the scope of the pharmacist and requires a referral to another healthcare professional. Y/N:

Further recommendations:

Follow up plan/date:

Create a comprehensive drug list including current prescriptions, OTC, NHP. This is to be printed for the patient. The pharmacist and patient both are required to sign. Completed, Y/N:

*Note: This is intended as a supporting documentation tool. Health care providers using this tool are responsible for ensuring content is up to date and all relevant information has been collected and assessed. Pharmacy Association of Nova Scotia

Diabetes “dmassessment”

Here for CDM/DM visit (initial/follow up):

Does patient have a primary provider?

Insurance. Y/N/issues with coverage?

SUBJECTIVE :

List current MEDS for DM:

Is patient tolerating their medication? Y/N: Details:

Any issues with compliance?

Do you ever not take your medication because you can’t afford them?

Do you forget to take your medication?

Do you ever take more or less of your medication based on how you are feeling?

If the patient is taking injectable medication, was injection technique reviewed? Y/N If patient is taking injectable therapy, ensure patient is not re-using needles, that they have a sharps container, proper site rotation is being done)

Is the patient on proper medications for CV protection if necessary/is additional CV screening advised?

ACE/ARB (see vascular protection in CPG) and dose:

Statin (see vascular protection in CPG) and dose:

Low dose ASA (note there is only evidence for secondary prevention):

List other mediations patient takes regularly:

HYPO/HYPERglycemia:

Current experience with hypoglycemia:

Reviewed signs/sx of hypoglycemia as well as management. Y/N: Details:

Reviewed signs/sx of hyperglycemia as well as management. Y/N: Details:

MEALS/DIET:

breakfast:

lunch:

supper:

snacks:

drinks:

Review appropriate carbohydrate portions and advise to balance all carbohydrate foods with non-carbs such as lean protein, eggs, cheese, nuts, nut butters (natural) etc. Eat regularly to reduce glycemic variability. Y/N: Details:

Created individualized meal plan together? Y/N: Details:

Additional screening/education topics

Sick day management:

SADMANS medications reviewed and signs/sx dehyration:

Smoking status:

Alcohol intake:

Current exercise:

-Advise patient the goal is to work to 150min/week with 2 days of resistance.

Foot care (self checks at minimum):

Last eye exam (advise annual dilated exam):

Vaccination status:

-Annual influenza vaccine (HD if 65): Y/N:

-Covid-19 vaccines up to date: Y/N:

-Pneumococcal vaccines: See most up to date NACI statement on use of Pneu-C-20 and Pneu-C-15. -1 dose of PNEU-C-20 is a PFV for pts who haven't been previously vaccinated with P23: >65yoa OR pts with high risk medical/living conditions (includes: diabetes, chronic heart disease, chronic lung disease, smokers 50+) -For adults who have previously received a pneumococcal vaccine, NACI recommends that a single

dose of Prevnar20 be offered to adults 65+ who have received Pneu-P23 alone or both Pneu-C13 + Pneu-P23, if it has been >5 years since the last dose of a pneumococcal vaccine **BUT it's NOT PF.** One exception, those with highest risk conditions that received only 1 of these vaccines are eligible for Pneu-C-20 to complete series.
Patient up to date: Y/N:
-All other routine adult vaccinations for their age group (ex. publicly funded Td/Tdap, MMR and non-publicly funded such as HZ vaccine): Y/N:
-RSV vaccine – Age 60+ not publicly funded. Y/N:
Vaccine Comments:

Overall Impact of diabetes on patient:

OBJECTIVE:

Labs (date):

A1C:

Ac Gluc:

egfr (check renal dosage chart to ensure no medication adjustments are required)

LDL (target < 2mmol/L):

Other labs if applicable (HDL, serum creatinine, microalbuminuria, creatine kinase, LFT, sodium, potassium):

Last UACR(should be completed yearly to screen for CKD):

BP reading in office (target < 130/80mmHg):

BP readings from home:

Is at home monitoring recommended?

POCT A1C (if needed):

POCT lipids(if needed):

Weight/BMI:

Glycemic control

Other: Explain any reason why higher targets are suggested for example: frail elderly:

Device used to monitor blood glucose levels:

Is the patient a candidate for continuous glucose monitoring CGM?

Review of home readings:

Is at home testing recommended? Frequency suggested:

Review blood glucose targets with patient (4-7 mmol/L, fasting 8-10mmol/L post prandial or 5-10mmol/L post prandial if not to target)

ASSESSMENT:

Drug related problems:

Opportunities for intervention:

Adaptions to current medications:

Additional medications recommended:

Additional monitoring required by patient:

PLAN:

1. What are your health goals/ what is something you'd like to focus on for the next visit? (sleep hygiene, stress/anxiety management, dietary changes, physical activity, weight management, smoking cessation)

List patient goal(s) and plan to achieve (include intervention, monitoring and follow up plan):

2. Medication plan (include intervention, monitoring and follow up plan):

3. Plan for monitoring of blood pressure and glucose (if applicable, or different than above):

4. Need for referral:

5. Follow up:

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STREP “strepassessment”

Here for Group A Strep Assessment: Y/N:

Does patient have a primary provider?

S/O

onset of sx:

Any sx consistent with viral infection?:

Age:

CENTOR SCORING FOR 3-14y/o

-Absence of cough (1 pt) ?:

-Tender or swollen anterior cervical lymph nodes(1 pt)?:

-Exudate or swollen tonsils(1 pt):

-Fever (1 pt):

Additional scoring for 15+

age 15-44: 0pt

Age 45+: -1pt

TOTAL SCORE:

Score -1 to 2 use symptomatic treatment with OTC and nonpharm

Score = or >3 then perform POCT. If positive treat with a/b, if negative, symptomatic treatment with follow up in 3-5 days

Score of 2- pharmacist may use clinical judgement and swab if deemed appropriate

RED flags present?(REFER- see below):

-< 3 years of age

-Severely ill refer to hospital for immediate care

-Potential complications: scarlet fever, suppurative complications (peritonsillar abscess, otitis media, sinusitis, skin infection, signs of glomerular nephritis)

-if symptoms worsen, unilateral neck swelling, unwell/toxic appearance, respiratory distress, stridor, trismus, drooling, hot potato voice, torticollis, neck stiffness/fullness

medication allergies?

PMhx/other regular medications:

history of anaphylaxis to previously prescribed abx (if rash to penicillin, can use cephalexin , if anaphylaxis, can use macrolide- see form)

A/P:

POCT advised ? :

result :

discussed OTC management

Advised patient they are contagious until on abx X 24 h

Advised patient rtc or see physician if sx worsen/change over next 2-3 days or are not improving

If unilateral neck swelling develops seek medical attention

rx given ? (Penicillin V first line = or <27kg give 300mg BID x 10 days. > 27 kg: 600mg BIDx 10 days

Amoxicillin; Peds 50mg /kg /day X 10/7 (max 1 g daily) Adults 1 g daily or 500mg bid for 10 days

See Meds: PANS Group A strep for other prescription options for pen allergy pts

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UTI “utiassessment”

Here for UTI consult

Does pt have a primary provider?

S/O

Has had previous UTI diagnosed by physician/NP? if no-->refer

Has the patient had a UTI diagnosed in the last 4 weeks ?If yes--> refer

Is this the 2nd UTI in past 6 months or 3rd UTI in last year? if yes--> Refer

Does the patient present with the following signs/sx:

frequency:

urgency:

suprapubic discomfort:

dysuria:

no vaginal sx: (if yes--> refer)

A:

Are the symptoms likely caused by medications?

Are any red flags present? (if yes--> refer)

Fever(>38C):

Dyspareunia:

vaginal discharge and/or irritation:

Chills:

Nausea/vomiting:

Flank pain:

Malaise:

Significant gross hematuria:

agitation or confusion (seniors):

patient has a catheter:

Patient is pregnant:

patient is immune compromised:

Symptoms have lasted > 14 days:

abnormal function or structure (spinal cord injury, neurogenic bladder, renal stones, renal dysfunction)

uncontrolled diabetes

taking meds that compromise immune system?:

Is the patient's biological sex female: if no--> refer

P:

nitrofurantoin 100mg bid for 5 days - first line

See other options under Meds, PANS UTI

patient advised to return for f/up if no sx improvement/sx worsen within 2 days of starting antibiotics

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COPD “copdassessment”

Does the patient have a primary provider?

S/O:

History including any diagnostic tests/dates (PFT/spirometry, chest x-ray, CT scan, arterial blood gases) on file:

Smoking status:

Long term exposure to smoke (1st or 2nd hand)?:

Long term exposure to chemical fumes/vapors/dust?:

Dyspnea/SOB:

Wheezing?

chest tightness?

Frequent cough?

Chronic cough?

Chronic sputum?

Frequent respiratory infections?:

High BMI?:

Lack of energy?

Swelling of ankles/feet ?:

Use of at home O2?:

Family member with asthma?

General allergies?

Any related medical conditions?

Current regime:

Is patient compliant (how many doses do they miss per week) :

Do you ever take more and less doses based on how you are feeling?

Do you have drug coverage? Do you ever not take your meds because you can't afford them?

Has patient had exacerbation in past year?

Frequency of use of SABD: (Ventolin should last ~11.5 months):

Is the patient up to date on immunizations?

-Annual influenza vaccine (HD if 65+)

-Covid-19 vaccine up to date:

- RSV vaccine – Age 60+ not publicly funded.

-Pneumococcal vaccines: -Pneumococcal vaccines: See most up to date NACI statement on use of Pneu-C-20 and Pneu-C-15. -1 dose of PNEU-C-20 is PFV for pts who haven't been previously vaccinated with P23: If pt is >65yoa OR pts with high risk medical/living conditions (includes: diabetes, chronic heart disease, chronic lung disease, smokers 50+). For adults who have previously received a pneumococcal vaccine, NACI recommends that a single dose of Prevnar20 be offered to adults 65+ who have received Pneu-P23 alone or both Pneu-C13 + Pneu-P23, if it has been >5 years since the last dose of a pneumococcal vaccine **BUT it's NOT PF.** One exception, those with highest risk conditions that received only 1 of these vaccines are eligible for Pneu-C-20 to complete series.

-All other routine adult vaccinations for their age group (ex: PFV Td/Tdap, MMR and non-publicly funded such as hz vaccine)?

**see immunization Canada for full adult immunization chart

CAT score (>10 = intervention required):

MCR >3 = intervention required):

A:

Review proper inhaler technique and change device if warranted

Is patient currently on LAMA/LABA +/- ICS +/- SABD? (see guidelines)

Would patient benefit from a change in therapy / is there a DRP ?

Recommended interventions (based on CAT/MCR scores above):

DRP:

smoking cessation (max dose for patches = 84mg + gum/inhaler prn):

vaccination:

Adjust therapy?:

change device to increase compliance?

Non drug interventions: setting health goals and outline a plan to meet these (examples: physical activity, weight management, sleep hygiene, managing stress/anxiety)

P:

Monitoring: recommend a daily log of : level of dyspnea at rest and with exercise, cough, wheeze, sleep quality/night waking, impact on daily activities, need for increased use of puffers, exacerbations, need for hospitalization

-have patient book in for consult if any changes or concerns with above monitoring parameters

changes :

Follow up:

Referral? :

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Conjunctivitis “conjunctivitisassessment”

Subjective

-generalized/diffuse redness of the conjunctiva – Y/N
-inflammation of the conjunctiva and/or eyelid -Y/N
-presence of itch (if present: minimal, moderate, severe) – Y/N:
-discharge (if present: minimal, moderate, profuse) (purulent, mucopurulent, mucoid/serous) Y/N:
-eyes involved: bilateral or unilateral -
-onset:
-measured/products tried to treat eye (include name, how used, duration of use, outcome)
-has patient experienced similar symptoms/diagnosed with conjunctivitis in the past? Y/N
-if yes, provide details and treatment used:

Red Flags (if yes to any REFER)

-age less than 3 months (consider referral under age 2)
-wears contact lenses (counsel to remove lenses immediately)
-has history of ocular disease (closed angle glaucoma, iritis, scleritis, keratitis. NO need to refer for open angle glaucoma)
-moderate to severe pain
-severe photophobia and/or severe foreign body sensation
-changes in vision (blurred vision or halos)
-irregular pupils
-ocular trauma (including recent surgery)
-severe headache and/or nausea
-rash with/with out vesicles around eye/eyelid/nose (consider shingles assessment)
-hyper purulent discharge (green-yellow) with rapid onset
-visible corneal opacity/haze
-ciliary flush (redness concentrated in ring around cornea) esp if unilateral
-focal redness not diffuse redness

Allergies:

Conditions: Relevant (Medical) Conditions

-Sjogren’s, rheumatoid arthritis, thyroid disease, rosacea Y/N:
Relevance: Consider differential diagnosis. Rule out DRY EYE
- History of atopy (asthma, allergic rhinitis, atopic dermatitis) Y/N:
Relevance: *Helps confirm ALLERGIC conjunctivitis*
-Pregnant or Breastfeeding Y/N:
Relevance: Precaution for certain treatment option

Relevant medications:
- Anticholinergic drugs, beta blockers, hormonal contraceptives/estrogen containing products Y/N:
Relevance: Consider differential diagnosis. Commonly associated with dry eye.

-Ophthalmic products Y/N:
Relevance: rule out hypersensitivity reaction or drug induced dry eye syndrome

Other
-Contact with known allergen. Y/N (specify):
Relevance: suspect ALLERGIC conjunctivitis
-Current upper respiratory tract infection Y/N:
Relevance: suspect VIRAL conjunctivitis
-Current otitis media infection Y/N:
Relevance: suspect BACTERIAL conjunctivitis
-Recent contact with person(s) experiencing eye infection or "pink eye" Y/N:
Relevance: suspect BACTERIAL or VIRAL conjunctivitis

Objective

See PANS form for Differential Diagnosis of Bacterial, viral, allergic, other

Symptoms include:

Assessment

-Diagnosis:

Notes

Referral if signs/symptoms are not consistent with conjunctivitis or if diagnosis is viral conjunctivitis. In these cases, the patient requires an assessment by another healthcare professional.

Notes:

Plan:

Non-Pharmacological Tips for Viral or Bacterial Conjunctivitis
• Avoid touching the eye; wash hands if you do.
• Wash hands frequently
• Use separate towels and pillow cases
• Discard any used/opened eye drops/ointments used during conjunctivitis
• Discard any used contact lenses/cases and discontinue use until symptoms resolve
• Discard any cosmetics that may be infected

Non-Pharmacological Tips for All types Conjunctivitis
• Clean eye lid/crust with baby shampoo diluted with warm water

Additional Counselling:

-Allergic: Avoid allergen when possible. Consider wearing sunglasses/eye glasses to prevent allergen from getting into the eye. Avoid rubbing your eyes. Use a cold compress to relieve eye swelling and itch. -
- Consider also if allergic rhinitis symptoms are present. See PANS Algorithm.
- Bacterial: Highly contagious. Use a warm compress to soften crust in the mornings. An eye wash/irrigation can be used to clean eyes.
-Viral: Highly Contagious. Should be self-limiting and resolve on its own in a similar time frame as a common cold

Medication

-Bacterial options: polymyxin B-gramicidin, polymyxin B + trimethoprim, erythromycin 0.5% opth ointment, fusidic acid 1% viscous opth drops, tobramycin 0.3% drops or opth ointment

-Allergic, first line options: ketotifen fumarate 0.025% drops, olopatadine 0.1% / 0.2% / 0.7% drops. Other options include prevention: sodium cromoglycate 2% or lodoxamide 0.1% drop. Lubricating drop/ointment, pheniramine 0.3#/naphazoline 0.025%, antazoline 0.51%/naphazoline 0.051% drop, oral antihistamine

Follow up plan:

-Bacterial: Patient to contact the pharmacy in 2-3 days if no symptom improvement
-Allergic: Patient to contact the pharmacy in 3 days if treating a current episode to discuss adverse effects and if no improvement/worsening symptoms
-Patient instructed to seek medical attention if symptoms worsen or change, red flags present

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Mild Skin: Eczema/Contact Dermatitis/Urticaria "mildskinassessment"

Use other macro for impetigo or fungal skin infection

S/O:

-pt has dry patches of skin, itchy, possible redness. Y/N:

-less than 30% of body: Y/N Refer if yes

-pt has been in contact with something resulting in rash and symptoms

Allergies:

Relevant Medical conditions:

Relevant Medications:

Assessment:

Notes:

Referral if signs/symptoms are not consistent with a mild skin condition and requires an assessment by another healthcare professional:

Notes

Plan:

Medication options: hydrocortisone 1 or 2 % cream/oint/lotion, hydrocortisone valerate 0.2% cream/oint, betaderm 0.05 or 0.1% cream/oint, aristocort R 0.1% cream/oint, mometasone 0.1% cream/oint/lotion, amcinodine 0.1% cream/oint/lotion, clobetasol 0.05% cream/oint/lotion

Non pharm:

Corticosteroids: Avoid triggers that may cause irritation, avoid scratching, and apply moisturizers liberally as needed. Use steroids sparingly, and clean/dry area before applying. □ Antibiotics: Apply until lesions have resolved. Crusts may be removed with warm water
Follow up:

Patient to self monitor and follow up with pharmacy in 7 days if symptoms don't resolve or if there is an issue with tolerability/ADR

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Impetigo

S/O

-presence of vesicles/blisters, surrounding erythema

-lesions may be tender and itchy

-lesions are inflamed or swollen with/without exudate or crusting (honey colored crusted erosions)

-REFER if there is fever, vomiting, nausea, painful lesions, fatigue OR immunocompromised

Allergies:

Relevant Medical condition:

Relevant Medications:

Assessment

Notes:

Referral if signs/symptoms are not consistent with a mild skin condition and requires an assessment by another healthcare professional.

Notes:

Plan:

Medication: Fucidin 2% or Mupirocin 2% cream or ointment Apply TID x 7-10 days

Non pharm: Antibiotics: Apply until lesions have resolved. Crusts may be removed with warm water, saline, or soap and water compresses applied for 10-15 minutes 3 or 4 times daily. Reduce transmission by washing hands frequent and avoid touching lesion.

Follow up:

Patient to self-monitor and follow-up with pharmacy in 7 days if symptoms don't resolve or if there's an issue with tolerability/ADR

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Fungal skin infection “fungalskinassessment”

S/O:

-patient has red patches of skin, itchy

-patches may contain many small papules

-satellite lesions may be present

-borders are irregular

-white patches/borders around folds of skin (ex: in between toes)

REFER if: fever, chills, or fatigue present OR uncontrolled diabetes OR immunocompromised

Allergies:

Relevant Medical Conditions:

Relevant Medications:

Assessment:

Notes:

Referral if signs/symptoms are not consistent with a mild skin condition and requires an assessment by another healthcare professional:

Notes

Plan:

Medication options: Clotrimazole 1% cream, miconazole 2% cream, Lamisil 1% cream/spray, Ketoderm 2% cream, Lotriderm 1% or 0.05% cream, Loprox 1% cream/lotion

Non-pharm: Antifungals: Keep affected area dry and wear loose-fitting, cotton clothing/moisture absorbing synthetics. Non-medicated powders may help absorb moisture, avoid using cornstarch. Apply antifungal to lesions and 2 cm around and continue treatment 1 week after symptoms resolve.

Follow up: Patient to self-monitor and follow-up with pharmacy in 7 days if symptoms don’t resolve or if there’s an issue with tolerability/ADR

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Allergic Rhinitis assessment “allergicrhinitisassessment”

S/O

-patient is experiencing runny nose, nasal congestion, sneezing and/or itchy eyes. Y/N:

-patient reports symptoms are mild and persistent (lasting 4 days or more per week OR 4 or more weeks at a time). Y/N:

-Patient reports symptoms are moderate and intermittent (lasting less than 4 days per week OR less than 4 weeks at a time)

If yes then continue.

-Patients symptoms are:

-What is most bothersome:

-Has pt tried anything for allergies in the past? Y/N:

If yes, what was it, was it effective:

Red flags present, if yes, REFER

-age less than 2 years. Y/N:

-pregnancy Y/N:

-shortness of breath or wheezing Y/N:

-persistent headache, eye or facial pain Y/N:

-signs of infection Y/N:

Allergies:

Relevant medical conditions:

Relevant medications:

Assessment

Diagnosis:

Notes:

Referral: Patient is experiencing signs and symptoms that are not consistent with allergic rhinitis and/or complicating factors and requires referral to another healthcare professional. Y/N:

Notes:

Plan

Medication: Intranasal corticosteroids: budesonide 64mcg or 100mcg, beclomethasone 50mcg, mometasone 50mcg, ciclesonide 50mcg, fluticasone furoate 27.5mcg, triamcinolone 55mcg
Second generation antihistamine: bilastine, cetirizine, desloratadine, fexofenadine, loratadine, rupatadine

Non-pharm: avoid allergen, avoid tobacco smoke, intranasal saline spray, lubricating eye drops, cold/warm compress to reduce eye symptoms

Follow up: patient to self monitor for side effects/tolerability and efficacy for 7-14 days. Patient can call clinic if needed.

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Contraception Initial Assessment Part B "contraceptionassessment"

-Contraception specific intake form (Part A) should be completed and reviewed before starting the service Y:

- Verbal consent to Provide the Service has been Provided by the Patient. For minors, the pharmacist has assessed that the patient is able to understand nature and/or Consent provided by Patient's Agent (if patient is not a mature minor). Y/N:

-Pt is aware that in every 12 month period, 1 initial assessment is covered with the NSH card, plus 1 subsequent assessment with change in therapy and 1 subsequent assessment without change in therapy and confirms has not had assessments any other pharmacies in the last 12 months. Y/N:

Subjective/objective:
-Reason for contraception and background comments:
-Stop assessment if hormones are for a reason other than to prevent contraception. Y/N:
-Sex assigned at birth:
-Contraception background comments:
-Menstrual history comments:
-Medical history and allergies, comments:
-Current or hast breast cancer, active liver disease, cirrhosis or hepatic tumor? If Yes, refer for further consultation and/or discuss non-hormonal contraception
-History of MI, IHD, valvular heart disease, DVT, PE, stroke, thrombophilia, thrombocytopenia, diabetes with microvascular complications, history of hypertension, active systemic lupus erythema with APL antibodies, uncontrolled IDB, history of bariatric surgery, smokes greater than 15 cigarettes/day and over 35 yoa? If YES to any of these, US MEC found at
https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html
-Medical risk factors: Multiple risk of atherosclerotic CVD?(older age, BMI>30kg/m2, smoking, diabetes, hypertension, low HDL, high LDL or TG. OR migraine with/without aura?
If yes, US MEC. If no, continue.
-Lifestyle and sexual history: Discuss with patient the risks of STI/vaccine preventable illnesses and/or risk of sexual assault. No issues, continue prescribing. OR refer for further consultation.
-Drug Interactions: Emergency contraception? (for any progestin containing HC (including CHCs) should initiate 5 days after UPA administration and use back up for those 5 days plus 7 more days
-Is patient taking any of the following: Antimicrobial therapy, anti-retroviral therapy, St John's Wort, anti-seizure medication (lamotrigine, carbamazepine, phenobarbital, phenytoin, topiramate, primidone, oxcarbazepine). IF yes, US MEC
Comments/notes:

Assessment:
-Patient would benefit from hormonal contraception therapy: Y/N:
-Patient has been referred for further consultation because:

Plan: various options are listed below
-IUC: Phc has collaborated with the following provider who will be responsible for insertion. Dr/NP:
-Implant: Phc has collaborated with the following provider who will be responsible for insertion. Dr/NP:
-While waiting for insertion (IUC or implant) an additional contraceptive method can be prescribed.
-Progestin only options: norethindrone 0.35mg pill or Depo-medroxyprogesterone acetate injection

-Combination hormonal contraceptive: monophasic combination pill, multiphasic combination pill, multiphasic extended cycle combination pill, etonogestrel/ethinyl estradiol slow release vaginal ring, norelgestromin/ethinyl estradiol patch.

-Follow up plan:
(For initial prescription, you may want to call in 1-4 weeks then see the patient in 3 months)

Counselling:
-Counselling provided on common ADRs, warning signs (ex: VTE), missed doses, etc, and provided written information. Y/N:
-A comprehensive review of all options available for contraception, including non-hormonal, emergency contraception, and providing information on the effectiveness, benefits, and risks associated with each method. Y/N:
-Counselling about the risks, management, and screening options for sexually transmitted infections and any vaccines recommended for prevention. Y/N:
-Referral resources for STI (including post exposure prophylaxis), sexual dysfunction, induced abortion services and intimate partner violence. Y/N:
-Counselling regarding the importance and recommended frequency of screening tests such as breast and pelvic exams, mammograms, and Pap tests. Y/N:
-Provided patient education resources if desired (found in the PANS contraception form). Y/N:

-Notification was sent to primary provider. Y/N:
-If pt doesn't have a primary provider, A copy of the record was offered to patient and was accepted or declined:
*Note: This is intended as a supporting documentation tool. Health care providers using this tool are responsible for ensuring content is up to date and all relevant information has been collected and assessed. Pharmacy Association of Nova Scotia