PHARMACY HEALTH CARE SERVICES

PANS PHARMACY ASSOCIATION OF NOVA SCOTIA

Uncomplicated Cystitis Assessment

Note: ®=Refer

Name:		**Date of Birth:**	(<16) ®
Address:		**HCN:**	
Phone:		**Date:**	

Dr/NP:	**Phone:**	**Fax:**

☐ i. **Consent to Provide the Service has been Provided by the Patient**
☐ ii. Patient is aware that a maximum of two assessments (with or without rx) are covered at a pharmacy with NS Healthcard, within a rolling 12-month period (from first date of claim) and confirms has not had assessments at any other pharmacies within the last 12 months.

Initial Assessment	Previous episode of a UTI diagnosed by a doctor or nurse practitioner?	☐ Yes ☐ No®
	Was the patient diagnosed with a UTI in the past 4 weeks?	☐ Yes® ☐ No
	Is this episode the patient's second UTI in 6 months or 3rd in the past year (or more)?	☐ Yes ® ☐ No
Signs/ Symptoms	Does the patient have two or more of the following? ☐ Dysuria ☐ Frequency ☐ Urgency ☐ Suprapubic discomfort **AND** ☐ No vaginal symptoms	
	Does the patient have any of the following signs or symptoms? ® ☐ Fever (>38C) ☐ Chills ☐ Malaise ☐ Flank pain/Tenderness ☐ Nausea/Vomiting ☐ Significant gross hematuria ☐ Agitation or Confusion (seniors) Notes: _____	
	Does the patient have the following? ® ☐ Vaginal discharge ☐ Dyspareunia ☐ Vaginal irritation _____	
	Have the symptoms persisted for more than 14 days? ® ☐ Yes ® ☐ No	
Medical Background	Patient Allergies, Medical Conditions and Medications updated on Patient File _____	☐ Yes
	Is there any possibility you are pregnant or are you breastfeeding?	☐ Yes® ☐ No
	Does the patient have abnormal urinary tract function or structure? (indwelling catheter, spinal chord injury, neurogenic bladder, renal stones, renal dysfunction, etc.) _____ = eGFR or CrCl _____	☐ Yes® ☐ No
	Does the patient have any of the following? Uncontrolled diabetes, Conditions that compromise the immune system	☐ Yes® ☐ No
	Does the patient take medications that suppress the immune system?	☐ Yes® ☐ No
	Are the symptoms likely cuased by medications?:	☐ Yes ☐ No
	Biological Sex is Female (Ex. Transgender Female UTI classified as complicated UTI)	☐ Yes ☐ No®
	Other relevant info:	☐ Yes® ☐ No
Assessment	☐ The patient is experiencing symptoms of uncomplicated cystitis and would benefit from therapy. ☐ Patient referred for medical/nurse practitioner consult due to: _____ _____ _____	

Healthcare Providers are responsible for assessing all relevant details. This is a supporting documentation tool only.
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PHARMACY HEALTH CARE SERVICES

PANS PHARMACY ASSOCIATION OF NOVA SCOTIA

Prescription Hard Copy

Name:		**Date of Birth:**	
Address:		**HCN:**	
Phone:		**Date:**	

Dr/NP:	**Phone:**	**Fax:**

☐ **A prescribing record has been faxed to physician/NP**

Plan

For the most up to date recommendations, review the NSHA Antimicrobial Handbook

First Line Option

☐ nitrofurantoin (Macrobid®) 100 mg bid x 5 days

Second Line Option

☐ sulfamethoxazole/trimethoprim 800mg/160mg po bid x 3 days

☐ fosfomycin 3 g dissolved in ½ cup (125 mLs) cold water once daily x 1 day (reserved when alternates are not appropriate) __(if Pharmacare confirm code 02 _____)

☐ cephalexin 500mg qid x (5-7days)

☐ amoxicillin-clavulanate 875/125mg twice daily x (5-7 days) _____

Other Options (refer Antimicrobial Handbook, Spectrum App)

☐ _____

Follow-up date (3 days recommended): _____(Set reminder in software)

- Assess for significant improvement in all symptoms
- Determine if side effects are occurring (esp. severe diarrhea or rash)
- If worsening or not improving, refer to MD. If improving, ensure completion of therapy if applicable

☐ Faxed notification to primary care provider

Pharmacist Certification

I, the assessing pharmacist, have seen and assessed the patient in person

- The written prescription/assessment is within my scope of practice, skills, competencies, experience and is within the prescribing standards as outlined by the council.
- If an authorized prescription is being dispensed by the same prescribing pharmacist, the patient has been informed that in this case there is one less health care professional assessing the appropriateness of therapy for the above indication.

Pharmacist Signature/License #	Date Phone
Pharmacy Name	Fax

Prescribing Notes: TMP-SMX

o Associated with higher risk of renal injury, hyperkalemia, and sudden death if

- Patients aged 65 years and older ▪
- Patients on medications that can increase potassium: angiotensin converting enzyme inhibitor (ACEi), angiotensin receptor blocker (ARB), or K+ sparing diuretic (e.g. spironolactone)

o Regular monitoring of kidney function and electrolytes are recommended for patients with risk factors for hyperkalemia or prolonged duration of therapy.

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PHARMACY HEALTH CARE SERVICES

PANS PHARMACY ASSOCIATION OF NOVA SCOTIA

Fax Cover Letter

To:	From:
Fax:	Pages:
Phone:	Date:
Re:	cc:

Comments:

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PHARMACY HEALTH CARE SERVICES

PANS PHARMACY ASSOCIATION OF NOVA SCOTIA

Physician/NP Prescribing Notification

☐ Response Required ☐ For Your Knowledge

Dr/NP:	Phone:	Fax:
Pharmacy Name & Phone Number:		

Name:		**Date of Birth:**	
Address:		**HCN:**	
Phone:		**Date:**	

Plan

The following has been prescribed for the above patient, presenting with symptoms of uncomplicated UTI.

First Line Option

☐ nitrofurantoin (Macrobid®) 100 mg bid x 5 days

Second Line Option

☐ sulfamethoxazole/trimethoprim 800mg/160mg po bid x 3 days

☐ fosfomycin 3 g dissolved in ½ cup (125 mLs) cold water once daily x 1 day (reserved when alternates are not appropriate)

☐ cephalexin 500mg qid x (5-7 days) _____

☐ amoxicillin-clavulanate 875/125mg twice daily x (5-7 days) _____

Other Options (refer Antimicrobial Handbook, Spectrum App)

☐ _____

Follow-up

The Pharmacist will follow-up with the patient on: _____

I am referring the patient to their physician/NP for follow-up. Rationale:

_____

_____

_____

_____

Pharmacist Certification

I, the assessing pharmacist, have seen and assessed the patient in person

- Patient consent was obtained
- The written prescription/assessment is within my scope of practice, skills, competencies, experience and is within the prescribing standards as outlined by the council.
- If an authorized prescription is being dispensed by the same prescribing pharmacist, the patient has been informed that in this case there is one less health care professional assessing the appropriateness of therapy for the above indication.

Pharmacist Signature/License #	Date:

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