AWC Pharmacy First Consultation Form Vs4 Jan 15

CPWY Community Pharmacy West Yorkshire
Working to represent, support and promote community pharmacy

Pharmacist name		GPhC number	
Consultation date	/ /	Consultation time	:
Patient's Name		Date of Birth	
Address			
Full Postcode		Gender	Male / Female / Trans
GP Practice	Refer to list of AWC CCG GPs		

Ethnicity

□ White - British	□ Mixed - Any other mixed background	□ Black or Black British - Caribbean
□ White - Irish	□ Asian or Asian British - Indian	□ Black or Black British - African
□ White - Any other White background	□ Asian or Asian British - Pakistani	□ Black or Black British
	□ Asian or Asian British - Bangladeshi	□ Any other Black background
□ Mixed - White and Black Caribbean	□ Asian or Asian British	□ Any other ethnic group
□ Mixed - White and Black African	□ Any other Asian background	□ Not stated
□ Mixed - White and Asian	□ Chinese	□ Prefer not to say

Patient Eligibility (all must apply)

□ Patient present □ Exempt from prescription charges □ Consent to share details with GP
□ Current minor ailment □ GP practice part of AWC CCG

Consultation

Consultation Location □ Consultation room □ Another area of the pharmacy

Indication for advice / treatment (tick one)

□ Viral Symptoms with Cough	□Sore Throat Only	□Fungal skin infections	□Headache/Migraine	□Threadworms
□ Viral Symptoms without Cough	□Fever without viral symptoms	□Rash/dermatitis (not allergic/ fungal)	□Pain- Musculoskeletal	□Other (state) .....
			□Pain- Dental	
□ Cough Only	□Hay fever	□Vaginal Thrush	□Pain- Back pain	
□ Earache	□Allergy symptoms- skin	□Teething	□Pain- Other	

Second indication (Only if applicable) State from list above

Information and advice provided

Verbal advice provided (tick all that apply)	Printed information about ailment supplied
□ Symptoms (expected duration, what's normal)	□ patient.co.uk Health information sheet
□ Self-care messages	□ Self-care Forum factsheet
□ Antibiotic stewardship	□ Printed information not appropriate / suitable
Antibiotic leaflet supplied	□ Other ..... (state)

□ Pharmacy First antibiotic info sheet □ Not appropriate / suitable □ Other antibiotic leaflet.....

Medication supplied

□ **AWC cough leaflet issued to patient with explanation as to why cough medicine not given**

□ Beclometasone 50 mcg nasal spray (200 sprays)	□ IbuprofenSusp 100mg/5ml (100ml) SF	□ Mebendazole 100mg tablet (1)
□ Cetirizine solution 5mg/5ml (200ml) SF	□ Ibuprofen tablets 200mg (24)	□ Mebendazole 100mg tablet (4)
□ Cetrizine 10mg tablets (30)	□ Ibuprofen tablets 400mg (24)	□ Miconazole 2% cream (30g)
□ Chlorphenamine Syrup (150 ml) SF	□ Lidocaine +/- Cetalkonium /Cetylpyridinium teething gel (10/15g)	□ Paracetamol 500 mg Tablets (32)
□ Chlorphenamine Tablets 4 mg (30)		□ Paracetamol soluble tabs 500mg (24)
□ Clotrimazole 500mg pessary (1)	□ Loratadine syrup 5mg/5ml (100ml)	□ Paracetamol Susp SF 120 mg / 5 ml (100ml) SF
□ Clotrimazole cream 1% (20g)	□ Loratadine 10mg tablets (30)	□ Paracetamol Susp SF 250 mg / 5 ml (100ml) SF
□ Ephedrine 0.5% nasal drops (10ml)	□ Mebendazole suspension (30ml)	□ Sodium chloride 0.9% nasal drops (10ml)
□ Fluconazole 150 mg Cap (1)		

Referral	Outcome of Pharmacy First consultation
□ None required	□ Advice only
□ In-hours usual care to GP	□ Advice and medication supply
□ Urgent (via telephone) to GP	□ Non-urgent referral with advice
□ Urgent (via telephone) to NHS 111	□ Non-urgent referral with advice and treatment
□ Other	□ Urgent referral

Details of urgent referral:
e.g. who called, date and time of appointment

Patient Declaration – To be completed by the patient

NOTE - You **will** be asked to show proof that you do not have to pay prescription charges, such as a benefit book or exemption certificate

- □ A. is under 16 years of age
- □ B. is 16, 17 or 18 years of age and in full time education
- □ C. is 60 years of age or over
- □ D. has a valid maternity exemption certificate
- □ E. has a valid medical exemption certificate
- □ F. has a valid prescription prepayment certificate
- □ G. has a valid War Pension exemption certificate
- □ L. is named on a current HC2 charges certificate
- □ H. gets Income Support or income-related Employment and Support Allowance
- □ K. gets income-based Jobseeker's Allowance
- □ M. is entitled to, or named on, a valid NHS Tax Credit Exemption Certificate
- □ S. has a partner who gets Pension Credit guarantee credit (PCGC)

Pharmacist to complete Evidence of Exemption Seen:	
□ Yes	□ No

Where would you have gone if you hadn't had this pharmacy first consultation today?
Tick one option

□ GP
□ Accident and Emergency (A+E)
□ Called NHS 111
□ Contacted Out-of-Hours GP
□ Bought product
□ Done nothing
□ Other ……

Would you recommend this service to your friends and family?

□ Yes □ No □ Not sure

How did you hear about the Pharmacy First service? Tick one option below

□ Used it before
□ Informed by GP surgery
□ Informed by NHS 111
□ Informed by pharmacy
□ Poster
□ Other ……

After receiving this service at the pharmacy today I feel more confident to manage my minor ailments without seeing a Doctor

□ Yes □ No □ Not sure □ Don't know

After receiving this service at the pharmacy today I feel that next time I have a minor ailment I plan to visit a pharmacy before contacting my GP surgery or the NHS 111 service

□ Yes □ No □ Not sure □ Don't know

I have received treatment and advice as overleaf. I agree the information can be shared with my GP as named overleaf and NHS Airedale, Wharfedale and Craven CCG for audit and pharmacy payment purposes.

Exemption declaration: I declare that the information I have given on this form is correct and complete and I understand that if it is not, appropriate action may be taken. I confirm proper entitlement to exemption. To enable the NHS to check I have a valid exemption and to help prevent and detect fraud, I consent to the disclosure of relevant information on this form to appropriate NHS and governmental bodies.

Patient Signature (or parent / guardian if under 16)	**Date**

Pharmacist Declaration

The above patient was accepted onto the Pharmacy First Service and was provided with advice, information leaflet and treatment as detailed on this form and in accordance with the Service Specification.

Pharmacist Signature	**Date**

This data needs to be entered onto PharmOutcomes as soon as possible and within 48 hours of the consultation.

This form should be securely retained in the pharmacy for 6 months after the consultation after which time it should be shredded / treated as confidential waste.