

Consultation date: __/__/____

Time:__:__:

Practitioner name:_____

Patient Details

Name:		Postcode:	NHS Number:
Date of birth: __/__/____		Address:	Contact Details:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans			
Ethnicity:			
<input type="checkbox"/> White - British <input type="checkbox"/> Mixed – Any other mixed background <input type="checkbox"/> Black or Black British - African <input type="checkbox"/> White - Irish <input type="checkbox"/> Asian or Asian British - Indian <input type="checkbox"/> Black or Black British – Any other Black background <input type="checkbox"/> White – Any other White background <input type="checkbox"/> Asian or Asian British - Pakistani <input type="checkbox"/> Other Ethnic Groups - Chinese <input type="checkbox"/> Mixed – White and Black Caribbean <input type="checkbox"/> Asian or Asian British - Bangladeshi <input type="checkbox"/> Other Ethnic Groups – Any other ethnic group <input type="checkbox"/> Mixed – White and Black African <input type="checkbox"/> Asian or Asian British – Any other Asian background <input type="checkbox"/> Not stated <input type="checkbox"/> Mixed – White and Asian <input type="checkbox"/> Black or Black British - Caribbean			

GP Practice, Consent & Service Entry

The patient must be advised of the following information sharing that will take place: <ul style="list-style-type: none"> With your GP practice to inform them of the outcome of your consultation under the NHS Pharmacy First Service. The sharing of information about the service with NHS England as part of the service monitoring and evaluation; and The sharing of information about the service with the NHSBSA and NHS England for the purpose of contract management and as part of post-payment verification (PPV). 		GP Practice:
Consent (required): <input type="checkbox"/> Yes <input type="checkbox"/> No		Method of entry to service: <input type="checkbox"/> Signposted <input type="checkbox"/> Self-referral <input type="checkbox"/> Referral (via PharmOutcomes) <input type="checkbox"/> Email referral <input type="checkbox"/> Onward referral from another pharmacy
Referrer organisation: (if referred) <input type="checkbox"/> NHS 111 <input type="checkbox"/> NHS 111 Online <input type="checkbox"/> GP Practice <input type="checkbox"/> Emergency Department <input type="checkbox"/> Ambulance Service <input type="checkbox"/> Urgent Treatment Centre	Signposted from: (if signposted) <input type="checkbox"/> NHS 111 <input type="checkbox"/> NHS 111 Online <input type="checkbox"/> Ambulance Service <input type="checkbox"/> GP Practice <input type="checkbox"/> GP Practice Online <input type="checkbox"/> Emergency Department <input type="checkbox"/> Urgent Treatment Centre <input type="checkbox"/> Walk-in Centre <input type="checkbox"/> Other (please state) _____	Patient would have attended: (if self-referred) <input type="checkbox"/> NHS 111 <input type="checkbox"/> NHS 111 Online <input type="checkbox"/> Ambulance Service <input type="checkbox"/> GP Practice <input type="checkbox"/> GP Practice Online <input type="checkbox"/> Emergency Department <input type="checkbox"/> Urgent Treatment Centre <input type="checkbox"/> Walk-in Centre <input type="checkbox"/> Other (please state) _____
Referrer contact: (if referred)	Referrer ODS code: (if referred/signposted)	Referral reference: (if referred/signposted)

Patient Assessment

<input type="checkbox"/> Existing medical conditions (e.g. any LTC such as asthma, heart disease, respiratory conditions) <input type="checkbox"/> Allergies and sensitivities (e.g. penicillin) <input type="checkbox"/> Patient has a family history of medical conditions <input type="checkbox"/> Currently taking any medication (consider prescription and OTC) <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Clinical observations, tests or algorithms conducted (e.g. NEWS2, FeverPAIN) <input type="checkbox"/> Other _____ <input type="checkbox"/> None of the above	Established pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
	Anything taken to help with the condition to date? (if referred) <input type="checkbox"/> Yes <input type="checkbox"/> No
	Details: (if answered 'yes' above)
	Clinical notes/observations: (including any associated symptoms if identified)
Symptom duration: (if referred) <input type="checkbox"/> < 24 hours <input type="checkbox"/> 24-72 hours <input type="checkbox"/> > 72 hours	
Temperature: (if recorded) ____°C	

Patient name: _____ Date: ___ / ___ / ___

Patient Assessment

Does the patient have **2 or more** of the following symptoms to suggest acute bacterial sinusitis:

- Marked deterioration after an initial milder phase
- Fever (>38°C)
- Unremitting purulent nasal discharge
- Severe localised unilateral pain, particularly pain over the teeth (toothache) and jaw

Yes - offer high dose nasal corticosteroid (off-label) for 14 days (subject to inclusion/exclusion criteria in PGD) plus self-care and pain relief instead of antibiotics first line

No - offer high dose nasal corticosteroid (off-label) for 14 days (subject to inclusion/exclusion criteria in PGD)

'Red Flags' such as symptoms associated with sepsis, meningitis or cancer identified?

- Yes
 No

Details of red flag symptoms: (if identified)

Consultation Outcome

Treatment option considered:

First line:

- High dose fluticasone nasal spray
 High dose mometasone nasal spray

If the above are unsuitable or ineffective:

- Phenoxymethylpenicillin

If reported penicillin allergy:

- Clarithromycin
 Doxycycline

If pregnant:

- Erythromycin

For self-care only:

- None

Do any exclusion criteria apply: (see relevant PGD)

- Yes No

Reason for exclusion: (if excluded)

Consultation Outcome:

- Advice given only (no medicine supply)
 Medicines supply (continue to medicine supply)
 Referral into an appropriate locally commissioned NHS service, such as a patient group direction
 Non-urgent signposting to another service
 Urgent escalation to another service
 Other (please state) _____

No supply reason: (required if outcome is not 'medicines supply')

- Patient excluded under terms of PGD
 Patient does not consent to treatment
 Agreed through shared decision making that self-care was the preferred option
 Agreed through shared decision making to delay treatment and return if symptoms persist
 Other (please state) _____

Patient name: _____ Date: ___ / ___ / ___

Medicine Supply

Medicine name:		Levy status
Form:		<input type="checkbox"/> Pays for each prescription item <input type="checkbox"/> A – 60 years of age or over OR is under 16 years of age <input type="checkbox"/> B – 16, 17 or 18 and in full time education <input type="checkbox"/> D – Maternity exemption certificate <input type="checkbox"/> E – Medical exemption certificate <input type="checkbox"/> F – Prescription prepayment certificate <input type="checkbox"/> G – Prescription exemption certificate issued by MoD <input type="checkbox"/> L – HC2 (full help) certificate <input type="checkbox"/> H – Income Support or Income-related Employment and Support Allowance <input type="checkbox"/> K – Income-based Jobseeker’s Allowance <input type="checkbox"/> M – Tax Credit exemption certificate <input type="checkbox"/> S – Pension Credit Guarantee Credit (including partners) <input type="checkbox"/> U – Universal Credit and meets the criteria <input type="checkbox"/> HMP – Prisoner on release or released from secure accommodation
Strength:		
Quantity:		
Dose:		
Days supplied:		
Notes:		

Referral

Routine referral: (if necessary) <input type="checkbox"/> GP Practice <input type="checkbox"/> Out of hours GP <input type="checkbox"/> Other Community Pharmacy (complete onward referral form) <input type="checkbox"/> Other (please state) _____	ODS code of organisation: (if known)
Urgent referral: (if necessary) <input type="checkbox"/> GP Practice <input type="checkbox"/> Out of hours GP <input type="checkbox"/> Other Community Pharmacy (complete onward referral form) <input type="checkbox"/> Urgent Treatment Centre <input type="checkbox"/> 999 <input type="checkbox"/> A&E <input type="checkbox"/> Other (please state) _____	Reason for referral:

Notes

Including advice provided and actions for patient:
