

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		
<p>The patient must be advised of the following information sharing that will take place:</p> <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). <p>Consent (required): <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>GP Practice:</p> <p>Method of entry to service:</p> <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 <p>Consultation method:</p> <input type="checkbox"/> Face to face	
<p>Referrer organisation: (if referred)</p> <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	<p>Signposted from: (if signposted)</p> <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) _____	<p>Patient would have attended: (if self-referred)</p> <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) _____
<p>Referrer contact: (if referred)</p>	<p>Referrer ODS code: (if referred/signposted)</p>	<p>Referral reference: (if referred/signposted)</p>

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	<p>Anything taken to help with the condition to date? (if referred)</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Details: (if answered 'yes' above)</p>
<p>Symptom duration: (if referred)</p> <input type="checkbox"/> < 24 hours <input type="checkbox"/> 24-72 hours <input type="checkbox"/> > 72 hours <p>Temperature: (if recorded) °C</p>	<p>Clinical notes/observations: (including any associated symptoms if identified)</p>
<p>Established pregnancy?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

Patient name: _____ Date: ___ / ___ / ___

Patient Assessment

1. Does the patient have acute onset of symptoms including:

- In older children - earache
- In younger children - holding, tugging, or rubbing of the ear
- In younger children - non-specific symptoms such as fever, crying, poor feeding, restlessness, behavioural changes, cough, or rhinorrhoea.

AND does the patient have an otoscopic examination:

- A distinctly red, yellow, or cloudy tympanic membrane
- Moderate to severe bulging of the tympanic membrane, with loss of normal landmarks and an air-fluid level behind the tympanic membrane
- Perforation of the tympanic membrane and/or sticky discharge in the external auditory canal.

Yes (Continue to question 2)

No (Acute otitis media less likely, consider alternative diagnosis and proceed appropriately – continue to question 7)

2. Does the patient present with **ANY** of the following:

- Patient is systemically very unwell
- Patient has signs of a more serious illness
- Patient is high risk of complications because of pre-existing comorbidity (this includes children with significant heart, lung, renal, liver or neuromuscular disease, immunosuppression, cystic fibrosis and young children who were born prematurely)

Yes (Onward referral to GP/other provider required – continue to question 7)

No (Continue to question 3)

3. Does the child/young person have **otorrhoea** (discharge after eardrum perforation) **or eardrum perforation** (suspected or confirmed)

Yes (Offer amoxicillin subject to inclusion/exclusion – continue to question 7)

No (Continue to question 4)

4. Is the child under 2 years **AND** with infection in both ears?

Yes (Continue to question 5)

No (Continue to question 6)

5. Does the patient meet **ANY** of the following criteria:

- Severe symptoms based on clinician global impression
- Symptoms for >3 days.

Yes (Offer amoxicillin subject to inclusion/exclusion – continue to question 7)

No (Consider offering phenazone/lidocaine ear drops subject to inclusion/exclusion – continue to question 7)

6. Severity of symptoms

Mild (Offer self-care and pain relief – continue to question 7)

Moderate or severe (Consider offering phenazone/lidocaine ear drops subject to inclusion/exclusion – continue to question 7)

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

Yes

No

8. Details of red flag symptoms (if identified):

Consultation Outcome

Treatment option considered:

First line:

Phenazone/lidocaine ear drops

Or if indicated above:

Amoxicillin

If reported penicillin allergy:

Clarithromycin

If pregnant:

Erythromycin

For self-care only:

None

Do any exclusion criteria apply: (see relevant PGD)

Yes No

Reason for exclusion: (if excluded)

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) _____

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) _____

Patient name: _____ Date: ___ / ___ / ___

Medicine Supply

Medicine name:		Levy status <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
Form:		
Strength:		
Quantity:		
Age range: (for clarithromycin)	<input type="checkbox"/> Children 1-11 years (record weight below) <input type="checkbox"/> Children 12-17 years	
Body weight: (kg)		
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: