

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

'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:**

- Phenoxymethylpenicillin

**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)

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) \_\_\_\_\_

## Medicine Supply

Medicine name:

Form:

Strength:

Quantity:

Age range: (for clarithromycin)  Children 5-11 years (record weight below)  
 Children 12-17 years

Weight: (kg)

Dose:

Days supplied:

Notes:

Levy status

- Pays for each prescription item
- A** – 60 years of age or over OR is under 16 years of age
- B** – 16, 17 or 18 and in full time education
- D** – Maternity exemption certificate
- E** – Medical exemption certificate
- F** – Prescription prepayment certificate
- G** – Prescription exemption certificate issued by MoD
- L** – HC2 (full help) certificate
- H** – Income Support or Income-related Employment and Support Allowance
- K** – Income-based Jobseeker's Allowance
- M** – Tax Credit exemption certificate
- S** – Pension Credit Guarantee Credit (including partners)
- U** – Universal Credit and meets the criteria
- HMP** – Prisoner on release or released from secure accommodation

Patient name: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

## Referral

### Routine referral: (if necessary)

- GP Practice
- Out of hours GP
- Other Community Pharmacy (complete onward referral form)
- Other (please state) \_\_\_\_\_

ODS code of organisation: (if known)

Reason for referral:

### Urgent referral: (if necessary)

- GP Practice
- Out of hours GP
- Other Community Pharmacy (complete onward referral form)
- Urgent Treatment Centre
- 999
- A&E
- Other (please state) \_\_\_\_\_

## Notes

Including advice provided and actions for patient: