

Consultation date: \_\_/\_\_/\_\_\_\_ Time:\_\_:\_\_ Practitioner name:\_\_\_\_\_

**Patient Details**

|   |  |  |                  |
|---|--|--|------------------|
| Name:   |  | Postcode:  | NHS Number:      |
| Date of birth: __/__/____   |  | Address:   | Contact Details: |
| Gender:<br><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**

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| 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> |   | <b>GP Practice:</b>  |  |
| Consent: (required) <input type="checkbox"/> Yes <input type="checkbox"/> No  |   | <b>Method of entry to service:</b> <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>   |  |
| <b>Referrer organisation:</b> (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>  | <b>Signposted from:</b> (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> | <b>Patient would have attended:</b> (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> |  |
| <b>Referrer contact:</b> (if referred)  | <b>Referrer ODS code:</b> (if referred/signposted)  | <b>Referral reference:</b> (if referred/signposted)  |  |

**Patient Assessment**

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

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

## Patient Assessment

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| <p><b>1. Does the patient have shingles within 72 hours of rash onset?</b></p> <p><input type="checkbox"/> Yes – continue to question 2.<br/> <input type="checkbox"/> No – continue to question 3.</p>  | <p><b>2. Does the patient meet (ANY) of the following criteria:</b></p> <ul style="list-style-type: none"> <li>• Immunosuppressed</li> <li>• Non-truncal involvement (shingles affecting the neck, limbs, or perineum)</li> <li>• Moderate or severe pain</li> <li>• Moderate or severe rash (defined as confluent lesions)</li> <li>• All patients aged over 50 years</li> </ul> <p><input type="checkbox"/> Yes – continue to question 5.<br/> <input type="checkbox"/> No – continue to question 3.</p>   |
| <p><b>3. Does the patient have shingles up to one week after rash onset?</b></p> <p><input type="checkbox"/> Yes – continue to question 4.<br/> <input type="checkbox"/> No – Patient does not meet treatment criteria. Share self-care and safety-netting advice. Continue to question 5.</p> | <p><b>4. Does the patient meet (ANY) of the following criteria:</b></p> <ul style="list-style-type: none"> <li>• Immunosuppressed</li> <li>• Continued vesicle formation</li> <li>• Severe pain</li> <li>• High risk of severe shingles (e.g. severe atopic dermatitis/eczema)</li> <li>• All patients aged 70 years and over</li> </ul> <p><input type="checkbox"/> Yes – continue to question 5.<br/> <input type="checkbox"/> No – Patient does not meet treatment criteria. Share self-care and safety-netting advice. Continue to question 5.</p> |
| <p><b>5. 'Red Flags' such as symptoms associated with sepsis, meningitis or cancer identified?</b></p> <p><input type="checkbox"/> Yes<br/> <input type="checkbox"/> No</p>  | <p><b>6. Details of red flag symptoms: (if identified)</b></p>   |

## Consultation Outcome

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|--|--|
| <p><b>Treatment option considered:</b></p> <p><b>First line:</b></p> <p><input type="checkbox"/> Aciclovir</p> <p><b>Or if unsuitable (offer valaciclovir for):</b></p> <ul style="list-style-type: none"> <li>• Immunosuppressed patients</li> <li>• Adherence risk: already taking 8 or more medicines a day or is assisted in taking their medicines.</li> </ul> <p><input type="checkbox"/> Valaciclovir</p> <p><b>For self-care only:</b></p> <p><input type="checkbox"/> None</p>                                    | <p><b>Do any exclusion criteria apply: (see relevant PGD)</b></p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p><b>Reason for exclusion: (if excluded)</b></p>   |
| <p><b>Consultation Outcome:</b></p> <p><input type="checkbox"/> Advice given only (no medicine supply)<br/> <input type="checkbox"/> Medicines supply (continue to medicine supply)<br/> <input type="checkbox"/> Referral into an appropriate locally commissioned NHS service, such as a patient group direction<br/> <input type="checkbox"/> Non-urgent signposting to another service<br/> <input type="checkbox"/> Urgent escalation to another service<br/> <input type="checkbox"/> Other (please state) _____</p> | <p><b>No supply reason: (required if outcome is not 'medicines supply')</b></p> <p><input type="checkbox"/> Patient excluded under terms of PGD<br/> <input type="checkbox"/> Patient does not consent to treatment<br/> <input type="checkbox"/> Agreed through shared decision making that self-care was the preferred option<br/> <input type="checkbox"/> Agreed through shared decision making to delay treatment and return if symptoms persist<br/> <input type="checkbox"/> Other (please state) _____</p> |

