

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>GP Practice:</p>
<p>Consent: (required) <input type="checkbox"/> Yes <input type="checkbox"/> No</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>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>Established pregnancy?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
	<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>Clinical notes/observations: (including any associated symptoms if identified)</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)</p> ____°C	

Patient name: _____ Date: ___ / ___ / ___

Patient Assessment

1. Does the patient have **any of the 3** key diagnostic signs/symptoms:

- Dysuria (burning pain when passing urine)
- New nocturia (needing to pass urine in the night)
- Urine cloudy to the naked eye (visual inspection by pharmacist if practicable)

Number of symptoms:

- No symptom – continue to question 2.
- 1 symptom – onward referral required. UTI equally likely to other diagnosis. Continue to question 4.
- 2 or 3 symptoms – continue to question 3.

2. Are there other urinary symptoms:

- Urgency
 - Frequency
 - Visible haematuria
 - Suprapubic pain/tenderness
 - None of the above - UTI less likely. Discuss self-care and pain relief. If symptoms worsen rapidly or significantly at any time referral to GP or other provider as appropriate. Continue to question 4.
- Onward referral required. UTI equally likely to other diagnosis.
Continue to question 4.

3. Shared decision making approach using **TARGET UTI** resources.

Severity of symptoms:

- Mild symptoms** - in patients that describe their symptoms as mild consider pain relief and self-care as first line treatment. Ask patient to return to pharmacy if no improvement in 48 hours for pharmacist reassessment. Continue to question 4.
- Moderate to severe symptoms** - offer nitrofurantoin for 3 days (subject to inclusion/exclusion criteria in PGD) plus self-care. Continue to question 4.

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

- Yes
- No

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

Consultation Outcome

Treatment option considered:

- Nitrofurantoin

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

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: