New Mexico Pharmacist Association Test-To-Treat Informed Consent and Patient Intake Form

*By providing your consent to take a test for point-of-care testing voluntarily, you will be confirming that you understand the following:*

* *The test may require a nasal/oral swab and is not guaranteed to be painless.*
* *The test takes an average of no less than 30 to 60 minutes to return a result. Thus, you will be notified of the testing result(s) and given appropriate advice if appropriate.*
* *Test results will not be shared with any third party and kept confidential at the pharmacy.*
* *Variable results are possible in persons who are immunosuppressed or have other patient characteristics.*
* *No point-of-care test is 100% accurate.*
* *If the test result is positive, you will isolate and try to not infect others, and adhere to current any state guidelines.*

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent/Guardian Name (if Minor):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth and Patient Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient (leave blank if self):\_\_\_\_\_\_\_

Patient Primary Care provider (if any):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary care provider address/telephone (if any):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Patient Questions** |  |
| 1. What point-of-care test would you like to get today?
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| 1. What are your symptoms?
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| 1. What date did your symptoms first start?
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| 1. What is your age?
 |  |
| 1. What other medical conditions do you have?
 |  |
| 1. What allergies do you have (food, medications)?
 |  |
| 1. What medications do you take (prescription or over-the-counter)?
 |  |
| 1. Are you pregnant or breastfeeding?
 |  |
| 1. Have you received any vaccines in the past 2 weeks, of so, which ones?
 |  |
| 1. Have you had any medical procedures in the past 2 weeks, if so, which ones?
 |  |
| ***Pharmacist Intake Form*** |  |
| *Chief Complaint* |  |
| *Symptoms* |  |
| *Location of the Symptoms* |  |
| *When did the Symptoms Start?* |  |
| *What Medications have you Tried?* |  |
| *What Makes the Symptoms Better?* |  |
| *What Makes the Symptoms Worse?* |  |
| *Patient History* |  |
| *Family History* |  |
| *Social History (Beliefs, Perceptions)* |  |
| *Current Living Environment (Family Member with illness)* |  |
| *Confirmed Allergies/Hypersensitivities* |  |
| *History of Present Illness* |  |
| *Past Medical History* |  |
| *Medications (RX, OTCs)* |  |
| *Patient Risk Factors (if any)* |  |
| *Patient Additional Exposures (if any)* |  |
| *Immunocompromised state (HIV/AIDS) or Immunocompromised drug therapy (corticosteroids for greater than 2 weeks) (consider referral for Flu and Covid and must refer for Strep)* |  |
| *Determined to be clinically unstable (Refer All Patients)* |  |
| *History of rheumatic fever, rheumatic heart disease, scarlet fever, or strep induced glomerulonephritis (refer for Strep)* |  |

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| ***Test-to-Treat*** | ***Pharmacist Physical Assessment Form*** | ***Result(s)*** |
| *All Therapies* | *Age (for flu & strep, if <3 years, referral required)* |  |
| *Strep, Consider* | *Throat Exam Findings* *(any tonsillar exudate, swollen tonsils)* |  |
| *Strep, Consider* | *Lymph Node Palpation Exam Findings (swollen/tender)* |  |
| *Strep, Consider* | *Centor Score >1 required* |  |
| *All Therapies* | *Temperature* |  |
| *All Therapies* | *Weight (not needed for strep > 18 yrs of age)* |  |
| *Re-Review of All Therapies as Above* | *Current Medication List**Past Medication History**Allergies/Hypersensitivities* |  |
| *All Therapies* | *Confirm Pregnancy or Breastfeeding* |  |
| *All Therapies* | *Confirm Immunocompromised State* |  |
| *Covid, Flu Only* | *(High Risk Patient Vitals Collection)**Includes Blood Pressure, Pulse, Respiratory Rate, O2 Saturation* |  |
| *All Therapies* | *Primary Care Provider notified in 15 days of any RX* |  |
| *All Therapies* | *Follow-Up Completed if needed (required for flu 24-48 hours post prescribing)* |  |
|  |  |  |
| *Covid Only* | *Labs in past 12 months (kidney & liver function)**eGFR < 30 do not prescribe Paxlovid**eGFR* *>30-60 dose reduction**eGFR > 60 normal dosing**Child Pugh Score A,B normal dosing**Child Pugh Score C do not prescribe Paxlovid* |  |
| *Covid Only* | *Confirm Age,**Patient is >12 yrs and at least 40kg – Paxlovid OK**Patient is > 18 yrs – Molnupiravir OK* |  |
| *Covid Only* | *Must confirm no significant drug interactions – Paxlovid* |  |
| *Covid Only* | *Non-pharmacological therapy recommended* |  |
| *Additional Notes* |  |  |
|  |  |  |
| *Flu Only* | *Oxygen Saturation* |  |
| *Flu Only* | *Confirm Pregnancy, Breastfeeding, or Immunocompromised State (special cautions in antiviral prescribing, consider using oseltamivir)* |  |
| *Flu Only* | *Allergies/Hypersensitivities (dairy allergy, avoid zanamivir-contains milk proteins, sugar intolerance, avoid oseltamivir)* |  |
| *Flu Only* | *Received LAIV (Flumist) in past 2-15 days, would not benefit from influenza antiviral at this time (length of time is specific per antiviral)* |  |
| *Flu Only* | *Weight based dosing for oseltamivir**>40kg = 75mg BID**>23kg-40kg = 60mg BID**>15-23kg = 45mg BID* |  |
| *Flu Only* | *Weight based dosing for baloxivir**20kg-80kg = 40mg as one dose**>80kg = 80mg as one dose* |  |
| *Flu only* | *Kidney function CrCl < 10, oseltamivir dose adjustment is needed* |  |
| *Flu Only* | *Non-Pharmacological therapy recommended* |  |
| *Flu Only* | *Follow-up required in 24-48 hours* |  |
| *Additional Notes* |  |  |
|  |  |  |
| *Strep, As Above* | *-Throat Exam Findings* *(any tonsillar exudate, swollen tonsils)**-Lymph Node Palpation Exam Findings (swollen/tender)**-Centor Score >1 required* |  |
| *Strep Only* | *Adjunct therapy recommended (APAP, NSAID)* |  |
| *Strep Only* | *Confirm Immunocompromised State (for strep, if immunocompromised state/medications, referral required)* |  |
| *Strep Only* | *Confirm no history of rheumatic fever, rheumatic heart disease, scarlet fever, or GAS induced glomerulonephritis (if yes, referral required)* |  |
| *Strep Only* | *Confirm patient is clinically stable (if no, referral required)* |  |
| *Strep Only* | *Non-Pharmacological therapy recommended* |  |
| *Additional Notes* |  |  |

*Summary of Treatment and Dosing*

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| *Covid* |  |  |
| *Paxlovid* | *>12 yrs old, nirmatrelvir 150mg (300mg)/ritonavir 100mg x 5 days* | *Needs renal dosing**Check liver function**Confirm drug interactions* |
| *Molnupiravir* | *>18 yrs old, 800mg BID x 5 days* |  |
| *Flu* |  |  |
| *Oseltamivir in Pediatric**Oseltamivir in Adult* | *<15kg or less, 30mg BID x 5 days**>15 to23 kg or less, 45mg BID x 5 days**>23 to 40kg, 60mg mg BID x 5 days**>40kg, 75mg BID x 5 days**75mg BID x 5 days* | *Needs renal dosing* |
| *Zanamivir* | *>7 yrs old, 5mg inhalation BID x 5 days* | *Avoid in airway diseases* |
| *Baloxivir* | *>12 yrs old, 40kg to <80kg, 40mg single dose**>12 yrs old, >80 kg, 80mg single dose* | *Avoid in pregnancy, breastfeeding, immunocompromised* |
| *Strep* |  |  |
| *Amoxicillin in Pediatric**Amoxicillin in Adult* | *25mg/kg BID x 10 days; max 500mg per dose**500mg BID x 10 days* |  |
| *Penicillin VK in Pediatric**Penicillin VK in Adult* | *250mg BID or TID x 10 days**250mg QID for 500mg BID x 10 days* |  |
| *Cephalexin (PCN Allergy)* | *20mg/kg BID; max 500mg per dose* |  |