# Patient Group Direction for treatment of Herpes Zoster (Shingles) in patients over 18 years

# Notification of supply from community pharmacy

**CONFIDENTIAL WHEN COMPLETED**

Data protection confidentiality note: this message is intended only for the use of the individual or entity to whom it is addressed and may contain information that is privileged, confidential and exempt from disclosure under law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited.

|  |  |  |  |
| --- | --- | --- | --- |
| GP name | Click or tap here to enter text. |  | Pharmacy Stamp |
| GP practice address | Click or tap here to enter text. |  |  |
|  | Click or tap here to enter text. |  |
| The following patient has attended this pharmacy for assessment and potential treatment of Herpes Zoster (Shingles) | |  |
| Patient name | Click or tap here to enter text. |  |
| Date of birth/CHI | Click or tap here to enter text. |  | Pharmacist name  Click or tap here to enter text. |
| Patient address | Click or tap here to enter text. |  |
|  | Click or tap here to enter text. |  | GPhC number Click or tap here to enter text. |
| Postcode | Click or tap here to enter text. |  | DateClick or tap to enter a date. |

Following assessment (Tick as appropriate)

|  |  |
| --- | --- |
| Your patient has been given a 7 day course of aciclovir 800 mg five times daily | ☐ |
| Your patient has been given self-care advice only | ☐ |
| Your patient is unsuitable for treatment via PGD for the following reasons and has been referred:  Click or tap here to enter text. | ☐ |

Your patient has been advised to contact the practice if symptoms fail to resolve following treatment.

You may wish to include this information in your patient records.

**Patient consent**: I can confirm that the information is a true reflection of my individual circumstances and I give my consent to allow a pharmacist working under the terms of NHS Pharmacy First Scotland to provide the most appropriate advice and/or treatment for me. I also give my permission to allow the pharmacist to pass, to my own GP, details of this consultation and any advice given or treatment provided. I have been advised that some of the information may be used to assess the uptake of the service but this will be totally anonymous and not be attributable to any individual patient.

|  |  |
| --- | --- |
| Patient signature | Date |
| Click or tap here to enter text. | Click or tap to enter a date. |

This form should now be sent to the patient’s GP and a copy retained in the pharmacy