# Patient Group Directions for treatment of Seasonal Allergic Rhinitis (Hay fever)

# Patient assessment form

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| --- | --- | --- | --- |
| **Patient name and address (including postcode):**  | Click or tap here to enter text. | **Date of Birth /CHI:** | Click or tap here to enter text. |
| **Sex** | M ☐ F ☐ |
| **Date of assessment:** | Click or tap to enter a date. | **Patient is aware that GP practice will be informed:** | YES | ☐ | NO | ☐ |

## Patient clinical picture and related appropriate actions

|  |  |  |  |
| --- | --- | --- | --- |
| **Clinical features/symptom assessment** | **Yes** | **No** | **Actions** |
| Is patient presenting with typical clinical features of **SEASONAL** allergic rhinitis and alternative causes have been explored and are less likely:(e.g., Sneezing, nasal discharge, nasal itching, nasal congestion – bilateral symptoms typically developing within minutes following allergen exposure.Additional symptoms such as postnasal drip, itching of palate and cough; and features suggestive of chronic nasal congestion such as snoring, mouth breathing and halitosis.Associated eye symptoms such as bilateral itching, redness and tearing) | ☐ | ☐ | If **NO**, consider alternative diagnosis and appropriate treatment or refer if required  |
|  |  |  |  |
| Is the patient pregnant? | ☐ | ☐ | If **YES** to any, do not treat with PGDs, consider alternative treatment or refer if required |
| Is the patient breastfeeding? | ☐ | ☐ |
| Does patient have hypersensitivity to any of active ingredients or excipients of medications available under these PGDs? | ☐ | ☐ |
| **Other criteria specific to individual medications** |
| **Beclometasone 50microgram nasal spray** | **Yes** | **No** | **Actions** |
| Is the patient 6 years of age or over? | ☐ | ☐ | If **NO**, do not treat with this PGD, consider mometasone nasal spray PGD |
| Does the patient have single sided prolonged discharge, or nasal blockage in the absence of rhinorrhoea, nasal itching and sneezing? | ☐ | ☐ | If **YES** to any, do not treat with this PGD, consider alternative treatment or refer if required |
| Has the patient experienced recent trauma or surgery to nose where healing is not complete, or has untreated localised nasal infection? | ☐ | ☐ |
| Does the patient have symptoms associated with acute bacterial sinusitis e.g., fever, severe pain, purulent nasal discharge? | ☐ | ☐ |
| **Fexofenadine 120mg tablets** | **Yes** | **No** | **Actions** |
| Is the patient 12 years of age or over? | ☐ | ☐ | If **NO**, do not treat with this PGD, consider alternative treatment or refer if required |
| Has the patient had treatment failure or remained symptomatic despite using at least two other allergy products available over the counter in the last six months? | ☐ | ☐ | If **NO**, do not treat with this PGD, consider alternative treatment  |
| **Mometasone 50microgram nasal spray** | **Yes** | **No** | **Actions** |
| Is the patient 3 years of age or over? | ☐ | ☐ | If **NO**, do not treat with this PGD, consider alternative treatment or refer if required |
| Has the patient had treatment failure or remained symptomatic despite using at least two other allergy products available over the counter in the last six months? | ☐ | ☐ | If **NO**, do not treat with this PGD, consider alternative treatment |
| Does the patient have single sided prolonged discharge, or nasal blockage in the absence of rhinorrhoea, nasal itching and sneezing? | ☐ | ☐ | If **YES** to any, do not treat with this PGD, consider alternative treatment or refer if required |
| Has the patient experienced recent trauma or surgery to nose where healing is not complete, or has untreated localised nasal infection? | ☐ | ☐ |
| Does the patient have symptoms associated with acute bacterial sinusitis e.g., fever, severe pain, purulent nasal discharge? | ☐ | ☐ |
| **Olopatadine 1mg/ml eye drops** | **Yes** | **No** | **Actions** |
| Has the patient has been diagnosed with allergic conjunctivitis? | ☐ | ☐ | If **NO**, refer to optometrist for diagnosis |
| Is the patient 3 years of age or over? | ☐ | ☐ | If **NO** to any, do not treat with this PGD, consider alternative treatment or refer to optometrist if required |
| If patient is not pregnant, are they using effective contraception? (Where applicable) | ☐ | ☐ |
| Has the patient had treatment failure or remained symptomatic despite using at least one other allergy treatment for ocular symptoms available over the counter? | ☐ | ☐ |
| Has the patient been using olopatadine for 4 months or longer? | ☐ | ☐ | If **YES**, do not treat with this PGD, consider alternative treatment or refer to optometrist if required |
|  |
| Patient (or legal representative) has given informed consent to treatment with appropriate product? | ☐ | ☐ | If **NO**, patient is unable to receive treatment |

### **Preparation options and supply method**

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| **Medicine and strength** | **Regime** | **Supply method** |
| Beclometasone 50microgram nasal spray | *Adults and children over 6 years:*TWO puffs in each nostril TWICE daily until symptoms controlled (can then be reduced to ONE puff in each nostril TWICE daily, return to higher dose if symptoms recur).The minimum dose should be used at which effective control of symptoms is maintained. Total daily administration should not normally exceed EIGHT sprays. | PGD via UCF |
| Fexofenadine 120mg tablets | *Adults and children over 12 years:*ONE tablet daily |
| Mometasone furoate 50microgram nasal spray | *Adults and children over 12 years:*TWO sprays in each nostril ONCE daily until symptoms controlled (can then be reduced to ONE spray in each nostril ONCE daily for maintenance. If symptoms remain inadequately controlled, dose may be increased to FOUR sprays per nostril ONCE daily – dose reduction recommended following control of symptoms) *Children between 3 and 11 years:*ONE spray in each nostril ONCE daily |
| Olopatadine 1mg/ml eye drops | *Adults and children over 3 years:*Instil ONE drop in each eye TWICE daily. |

**Patient advice checklist**

|  |  |
| --- | --- |
| **Advice** | **Provided** **(Tick as appropriate)** |
| **General** |  |
| Explain mode of action, benefits of the medicine, possible side effects and their management | ☐ |
| Give general advice for managing high pollen count | ☐ |
| If symptoms do not improve or worsening symptoms, advise to seek advice initially from the pharmacy | ☐ |
| Advise to seek immediate medical advice in event of severe adverse reaction | ☐ |
| Patient information leaflet relating to medication(s) is/are given to patient | ☐ |
| **Beclometasone or mometasone nasal sprays** | ☐ |
| Explain initial priming, how to spray into nostril | ☐ |
| Advise that it may take 1 -2 weeks of treatment to obtain maximum effect | ☐ |
| Explain how to increase/reduce dose according to symptom control | ☐ |
| **Olopatadine eye drops** |  |
| Demonstrate instillation technique | ☐ |
| Advise on use with contact lenses/other eye drops | ☐ |
| Advise that care required if blurred vision occurs | ☐ |
| Advise that maximum treatment period of 28 days per bottle, and **FOUR** months in total | ☐ |
| Advise that if patient of child-bearing potential, effective contraception is required whilst using olopatadine | ☐ |
| Advise that benzalkonium chloride may cause irritation to eyes | ☐ |
| **Fexofenadine tablets** | ☐ |
| Advise to take tablet before a meal | ☐ |
| If taking aluminium or magnesium containing antacids – advise to leave at least 2 hours between administration of fexofenadine and these medicines. | ☐ |

**Communication**

|  |  |
| --- | --- |
| **Contact made with** | **Details (include time and method of communication)** |
| Patient’s General Practice (details) | Click or tap here to enter text. |

## Details of medication supplied and pharmacist supplying under the PGD

|  |  |  |  |
| --- | --- | --- | --- |
| Medication supplied | Click or tap here to enter text. | Batch number and expiry | Click or tap here to enter text. |

Additional medication supplied (if applicable)

|  |  |  |  |
| --- | --- | --- | --- |
| Medication supplied  | Click or tap here to enter text. | Batch number and expiry | Click or tap here to enter text. |
| Medication supplied | Click or tap here to enter text. | Batch number and expiry | Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| Print name of pharmacist | Click or tap here to enter text. | GPhC Registration number | Click or tap here to enter text. |
| Signature of pharmacist |

# Patient Group Directions for treatment Seasonal Allergic Rhinitis (Hay fever)

# 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/Address details |
| 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 Seasonal Allergic Rhinitis (Hay fever): |  |
| Patient name | Click or tap here to enter text. |  |
| Date of birth/CHI | Click or tap here to enter text. |  | Pharmacist nameClick 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)

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| --- |
| Presenting condition: Seasonal Allergic Rhinitis (Hay fever) |
| Sneezing ☐ | Nasal discharge ☐ | Nasal itching ☐ | Nasal congestion ☐ |
| Itchy eyes ☐ | Redness of eyes ☐ | Watery eyes ☐ |  |
| The patient has been given: |
| Beclometasone 50mcg nasal spray (200 doses) ☐ | Mometasone 50mcg nasal spray (140 doses) ☐ |
| Fexofenadine 120mg tablets (30 tablets) ☐ (60 tablets) ☐ | Olopatadine 1mg/ml eye drops (5ml) ☐ |
| The patient has been given self-care advice only | ☐ |
| The patient is unsuitable for treatment via PGD for the following reasons and has been referred:Click or tap here to enter text. | ☐ |

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. | Consent received☐ |

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