

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

Patient assessment form

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 will be informed:	YES ☐ NO ☐

Patient clinical picture and related appropriate actions

Clinical features/symptom assessment	Yes	No	Actions
Is patient over 18 years of age?	☐	☐	If NO, do not treat with this PGD. Refer to GP/OOH/ED as appropriate.
Does the rash affect a single dermatome?	☐	☐	If NO, do not treat with this PGD. Refer to GP/OOH/ED as appropriate.
Has rash been present for less than 72 hours?	☐	☐	If NO, do not treat with this PGD. Refer to GP/OOH/ED as appropriate.
Is shingles rash affecting areas other than those relating to dermatomes T1 – L2 e.g. extending to around eyes?	☐	☐	If YES to any of the exclusion criteria , do not treat with this PGD. Refer to GP/OOH/ED as appropriate.
Is patient already taking antiviral medication?	☐	☐	
Known hypersensitivity to aciclovir or any excipients?	☐	☐	
Does the patient have impaired gastrointestinal absorption e.g. Crohn's disease, ulcerative colitis?	☐	☐	
Does patient have acute diarrhoea and vomiting where aciclovir absorption could be impaired?	☐	☐	
Is the patient immunocompromised? E.g. auto-immune disease, current chemotherapy or immunosuppressant medication?	☐	☐	
Is the patient pregnant?	☐	☐	
Is patient systemically unwell?	☐	☐	
Known moderate to severe renal impairment? (eGFR <25mL/minute/1.73m ²)?	☐	☐	
Is this recurrent shingles? (Immunocompetent patient with a history of 2 or more episodes in last 12 months)	☐	☐	
Concomitant use of interacting medication?	☐	☐	
Has informed consent to treatment been obtained?	☐	☐	If NO, patient is unable to receive treatment.

Preparation options and supply method

Medicine and strength (Dispersible tablets strictly limited to those unable to swallow standard tablets)	Regimen	Supply method
Aciclovir 800 mg tablets	ONE tablet FIVE times daily spread evenly throughout the day during waking hours (usually at 4 hourly intervals) x 35	PGD via NHS Pharmacy First Scotland
Aciclovir 400 mg tablets	TWO tablets FIVE times daily spread evenly throughout the day during waking hours (usually at 4 hourly intervals) x 70	
Symptomatic management	Appropriate analgesia – paracetamol	NHS Pharmacy First Scotland, OTC or existing supply

Patient advice checklist

Advice	Provided (tick as appropriate)
How to take medication – with water, regularly and complete the course	☐
Ensure adequate fluid intake whilst taking aciclovir tablets	☐
Expected duration of symptoms - to seek medical assistance if symptoms worsen or are not resolving within 7 days	☐
Patient information leaflet relating to the medication is given to the patient	☐
Common side effects of medication e.g. nausea, vomiting, diarrhoea and abdominal pain, taste disturbance, photo sensitivity, pruritus, urticaria, fever, tiredness and occasionally headaches or dizziness.	☐
Check patient has access to symptomatic relief (use of analgesia – paracetamol)	☐
Avoid sharing of towels and clothes	☐
Maintain good hand hygiene	☐
Wear loose fitting clothes to minimise irritation	☐
Avoid use of topical creams and adhesive dressings as they can cause irritation and delay rash healing	☐
Person with shingles is infectious until all the vesicles have crusted over (usually 5-7 days after rash onset)	☐
Avoid contact with others wherever possible, if the rash is weeping and can't be covered. If the lesions have dried or can be covered, this is not necessary	☐
Person who has not had chicken pox or the varicella vaccine can catch chicken pox from person with shingles (if possible, avoid pregnant women, immunocompromised people and babies younger than 1 month old)	☐

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	Click or tap here to enter text.	Expiry date Click or tap to enter a date.
Print name of pharmacist	Click or tap here to enter text.	
GPhC registration details	Click or tap here to enter text.	
Signature of pharmacist		

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

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 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
Patient address	Click or tap here to enter text.	Click or tap here to enter text.
	Click or tap here to enter text.	GPhC number
Postcode	Click or tap here to enter text.	Click or tap here to enter text.
		Date
		Click or tap to enter a date.

Following assessment (Tick as appropriate)

The patient has been given a 7 day course of aciclovir 800 mg five times daily	☐
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.	☐

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.	Consent received ☐
--	--

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