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

# Patient assessment form

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| --- | --- | --- | --- |
| **Patient Name:**  | 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 consents to GP being informed:** | YES ☐ NO ☐(exclude if no consent) |

## Patient clinical picture and related appropriate actions

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| --- | --- | --- | --- |
| **Clinical features/symptom assessment** | **Yes** | **No** | **Actions** |
| Is patient over 18 years of age?  | ☐ | ☐ | If NO, do not treat and refer  |
| Does the rash affect a single dermatome? | ☐ | ☐ | If NO, do not treat and refer |
| Is shingles rash affecting areas other than torso e.g. eyes? | ☐ | ☐ | If YES, do not treat and refer |
| Rash appeared > 72 hours ago? | ☐ | ☐ | If YES, do not treat and refer  |
| New vesicles formed after 7 days of treatment? | ☐ | ☐ | If YES, do not treat and refer |
| Known hypersensitivity to aciclovir or any excipients? | ☐ | ☐ | If YES, do not treat and refer |
| Does the patient have impaired gastrointestinal absorption? | ☐ | ☐ | If YES, do not treat and refer |
| Is the patient immunocompromised? E.g. auto-immune disease, chemotherapy, immunosuppressant medication? | ☐ | ☐ | If YES, do not treat and refer |
| Is the patient pregnant? | ☐ | ☐ | If YES, do not treat and refer |
| Is the patient breast feeding? | ☐ | ☐ | If YES, do not treat and refer |
| Is patient systemically unwell, including symptoms of fever and headache?  | ☐ | ☐ | If YES, do not treat and refer  |
| Known moderate to severe renal impairment? | ☐ | ☐ | If YES, do not treat and refer  |
| Is this recurrent shingles? (Two or more episodes over the lifetime of a patient thought to be immunocompetent) | ☐ | ☐ | If YES, do not treat and refer |
| Is patient in severe pain which hasn’t responded to OTC analgesics? | ☐ | ☐ | If YES, do not treat and refer |
| Concomitant use of interacting medication e.g. probenecid, theophylline, cimetidine, mycophenolate? | ☐ | ☐ | If YES, do not treat and refer |
| Has informed consent to treatment been obtained? | ☐ | ☐ | If NO, do not treat and refer |

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

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| **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 (at 4 hourly intervals during waking hours) x 35 | PGD via NHS Pharmacy First Scotland |
| Aciclovir 400 mg tablets | Two tablets five times daily (at 4 hourly intervals during waking hours) x 70 |
| Symptomatic management | Appropriate analgesia – paracetamol or NSAID e.g. ibuprofen  | NHS Pharmacy First Scotland or OTC or existing supply |

|  |  |
| --- | --- |
| **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 or NSAID e.g. ibuprofen) | ☐ |
| 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 attending work 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) | ☐ |

**Patient advice checklist**

**Communication**

|  |  |
| --- | --- |
| **Contact made with** | **Details (include time and method of communication)** |
| Patient’s regular 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 |  |

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# 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 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)

|  |  |
| --- | --- |
| 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