

**Minor Ailments and**

**Contraception Service (MACS) Form**

Name of patient

Patient phone number

Personal Health Number

Informed consent?

* Yes

Minor ailment of concern/ contraception:

 Contraception  Dysmenorrhea  Headache  Shingles

 Acne  Dyspepsia  Hemorrhoids  Nicotine dependence

 Allergic rhinitis  Fungal infections  Herpes labialis  Threadworms or pinworms

 Conjunctivitis  Onychomycosis  Impetigo  Urinary tract infection

 Dermatitis  Tinea corporis infection  Oral ulcers  Urticaria, including insect bites

 allergic/contact  Tinea cruris infection  Oropharyngeal candidiasis  Vaginal candidiasis

 atopic  Tinea pedis infection  Musculoskeletal pain

 diaper rash  Gastroesophageal reflux disease

 seborrheic

**PATIENT ASSESSMENT**

PharmaNet checked? ☐ Yes

Patient eligible? ☐ Yes

Patient symptoms and signs:

Assessment of relevant medical history and medications:

Diagnosis:

**RECOMMENDATIONS** (may include medication(s), self-care strategies, and/or advice to seek medical attention from physician or other healthcare professionals)

Prescription issued? ☐ Yes ☐ No

Advised to seek medical attention from another healthcare professional? ☐ Yes; advised to see: ☐ No Details of prescription and/or other recommendations, with rationale:

**MONITORING and FOLLOW-UP PLAN**

**PROVIDERS NOTIFIED (if applicable)**

Primary care provider (name): \_ Date and method notified:

Other health care providers: Date and method notified:

**PHARMACY/PHARMACIST INFORMATION**

Pharmacy name: \_ Pharmacy address: \_ Pharmacy phone number:

Print name of pharmacist and licence number Signature of pharmacist Date signed