ADULT SCREENING FORM: GROUP A STREP

Phone 1
ax 1 1

Primary Care Provider ________________________ **Phone** _____________ **Fax** _____________ **Date** ____________

Upon suspicion for group A strep, we have performed a preliminary screening based on the CDC symptoms with the patient's consent.

Patient Information

Name ___________________________

Current Medications _______________________________
____
____
____

Health History _________________________________
____
____

Do you use home oxygen? Y / N Pregnant? Y / N

Date of Birth: ____________________ Age:______
BP1 ____ / ___ BP2 ____ / ___ Pulse ______
Phone Number: __________________
Drug Allergies ________________________________
Email: _______________________________________

Rapid Detection of Group A Strep Test

BD Veritor™ System Test Device Lot _______Expiry _____
RelativeSensitivity:95.4% Relative Specificity: 95.7%

History of Current Illness

Group A Strep Symptoms

- ☐ Sore throat, pain when swallowing
- ☐ Fever >100.4°F
- ☐ Red/swollen tonsils
- ☐ Tiny, red spots on roof of mouth
- ☐ Swollen lymph nodes (front of the neck)

Symptoms Not Suggestive of Group A Strep

- ☐ Cough
- ☐ Hoarseness
- ☐ Rhinorrhea
- ☐ Conjunctivitis
- ☐ Diarrhea

How long has the person had the symptoms? ____

Actions Taken to Date:____

Assessment

Score:

Absence of cough (1 point)
History of fever >100.4°F (1 point)
Presence red/swollen tonsils(1 point)
Swollen lymph nodes (1 point)

Total Score:

- ☐ 0-1 Strep test & antibiotic therapy are not indicated.
- ☐ 2-3 Strep test indicated.
  If positive, antibiotic therapy indicated.
- ☐ ≥4 Consider antibiotic treatment.

Pharmacotherapy Plan -- *PHYSICIAN'S RESPONSE REQUIRED FOR ANTIBIOTIC THERAPY*

Test Result___________________________________

☐ **Initiate antibiotic therapy:**

- ☐ Insert Medication
- ☐ Insert Medication
- ☐ Insert Medication
- ☐ Insert Medication

☐ **Patient to visit clinic**

☐ **Other:** ___________________________________

Supportive Care recommended by pharmacist:

- ☐ Insert
- ☐ Insert
- ☐ Insert
- ☐ Other: ________________________________

Pharmacist Follow-Up within 48 hours

Date:______________Pharmacist:_________________

Date: ___________________________________

Physician's signature: ___________________________

Disclaimer: This assessment does not constitute a medical diagnosis. Negative results do not preclude Group A Strep infection and should not be used as the sole basis for treatment.