Patient Consent Form

Rapid Diagnostic Testing & Screening

Patient name_____ Date of Birth_____/____/_____

Address_____ Telephone_____

I hereby authorize the pharmacist from **Shane's Pharmacy** to perform the following screening. I authorize the pharmacist to maintain a copy of this signed paper. I indemnify the organizing body and all persons connected with them from any and all claims that may result from my voluntary participation in the screening.

By initialing the box(es) below, I signify that I agree to allow those pharmacist affiliated with the pharmacy named above to administer the respective Rapid Diagnostic Testing & Screening for the fee of **$40.00 – Strep $45.00 – Flu**

☐ Influenza A+B

☐ Group A streptococcal (Strep A)

☐ Other (describe) _____

☐ Please list any drug allergies or chronic conditions _____

☐ I authorize the pharmacists above to contact my primary care doctor with the results of the above test(s)

Primary care doctor name _____
Address _____

Patient Signature _____
Name (print) _____
Representative (if applicable) ___Yes _____No _____Date _____
Representative Signature_____
Name (print)_____
Relationship of representative _____

Physician Written Order

Rapid Diagnostic Testing & Screening

Dr Andrew Burchett (physician) has authorized | Shane Clarambeau Shannon Zeeb Chintal Druyvestein Brandy Ludemann | (RPh/Pharm D)

from Shane's Pharmacy___ (pharmacy) on ____/____/_____to perform the above screenings

The Pharmacy and its pharmacists comply with the Health Insurance Portability and Accountability Act of 1996(HIPPA) with regard to the Protected Health Information you provide on this form. The pharmacy and its pharmacists take your health information privacy very seriously, and shall use, disclose, and maintain your Protected Information only as permitted by HIPPA.

Patient Screening Form

Diagnostic Testing & Screening

Streptococcal Pharyngitis

Patient name (print) _____ Date of birth ____/____/____

Address _____

Telephone _____ Age _____ Weight (kg) _____

Patient eligibility for testing

Eligible

- ○ 3 years and older
- ○ Symptoms consistent with GAS pharyngitis

Ineligible

○ Younger than 3 years old ○ Pregnant ○ Immunocompromised	Should be referred to their primary care physician

Patient symptoms

Normal

- ○ Sudden onset of sore throat
- ○ Fever >101.5
- ○ Headache
- ○ Nausea/vomiting/ abdominal pain
- ○ Tonsillopharyngeal inflammation
- ○ Patchy tonsillopharyngeal exudates
- ○ Palatal petechiae
- ○ Anterior cervical adenities

_____

_____

Symptoms started _____ (hours)

Abnormal

○ Fever >103 ○ Systolic blood pressure <100 mmHg ○ Pulse >100 beats per minute	Should be immediately referred to their primary care physician or an emergency department

The Modified Centor Score is utilized to assess patients presenting with symptoms of acute GAS pharyngitis. This scoring system assigns a point value to patients' symptoms. Patients' results will determine the course of action for recommending treatment.

Modified Centor Score

Symptom	Point Value	Patient Score
Absence of cough	+1	
Swollen and tender cervical lymph nodes	+1	
Fever >100.4	+1	
Tonsillar exudate or swelling	+1	
Age 3-14 years	+1	
Age 15-44 years	0	
Age 45 and older	-1	
Total Score		

Recommended treatment options

Modified Centor Score (points)	Management Strategy	Probability of GAS Pharyngitis
≤1	No antibiotic or culture necessary	<10 percent
2	Antibiotic based upon GAS rapid diagnostic test	11-17 percent
3	Antibiotic based upon GAS rapid diagnostic test	28-35 percent
≥4	Initiate empiric antibacterials	52 percent

Patients with a Modified Centor Score of 2 or 3 points and meet eligibility requirements should further be evaluated with a GAS pharyngitis rapid diagnostic test.

Based on Modified Center Score, patient is eligible to test

○ Yes ○ No

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