Group A Strep Form

Buena Vista Drug
Providing the service you deserve
www.bvdrug.net | 719.395.2481
Health Mart

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SALIDA PHARMACY & FOUNTAIN
EST. 2019

Phone: 719-530-4790
Fax: 719-530-4791

Patient Information

Name_____ **Date of Birth** _____
Phone_____ **Date**_____
Address_____
City _____ State _____
Zip Code _____

Current Medications_____
_____
_____
_____
Health History_____
_____
_____
Do you use at home Oxygen? Y / N Pregnant Y / N

Signs and Symptoms

Age _____ **Temperature** _____
Drug Allergies _____
BP1 ____/____ **BP2** ____/____ **HR** _____
RR _____
Lymph Node Status _____
Throat Visualization _____

☐ Sore Throat, Pain when swallowing
☐ Fever > 100.4◦F
☐ Red/swollen tonsils
☐ Tiny, red spots on roof of mouth
☐ Swollen lymph nodes

☐ Cough
☐ Hoarseness
☐ Rhinorrhea
☐ Conjunctivitis
☐ Diarrhea

Strep A Flip Information:
Lot _____**Expiration** _____

How long has the person had symptoms? _____

What actions were taken?
_____

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
☐ >4 Consider antibiotic treatment

Pharmacotherapy Plan -- *MAY REQUIRE REFERRAL WITH PHYSICIAN OR PUBLIC HEALTH*

Test Result_____

☐ **Medication Provided**
Medication Name_____

☐ **Referral to Hospital/PCP**
Provider Name_____

☐ **Referral to Public Health**
Provider Name_____

Date: _____
Testing Pharmacist: _____

Pharmacist Consultation Notes _____
_____
_____
_____
_____
_____
_____
_____

PHARMACIST MUST COMPLETE BOX BELOW

Pharmacist Follow-Up in 48 hours
☐ E-care Plan Initiated
Date:_____Pharmacist:_____

NEXT PAGE

Disclaimer: I hereby authorize the pharmacist from Buena Vista Drug to perform a Group A Strep Rapid Test. I authorize the pharmacists to maintain a copy of this signed form. 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 tests. By signing below, I signify that I agree to allow those pharmacists affiliated with the pharmacy named above to administer the strep test for a fee of $40.00. I understand that my insurance might not reimburse the fee for the test and hold the pharmacy and pharmacist harmless for any fees not reimbursed. 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. I understand the test that I am receiving is a rapid diagnostic test using antigens. Antigen tests look for viral proteins, which are highly specific, meaning that if you test positive, you are very likely infected. However, there is a higher chance of false negative with antigen tests, which means that a negative result cannot definitively rule out an active infection. If you have a negative result on an antigen test but have a recent exposure to strep, or are displaying many of the symptoms, you may wish to take a PCR test to confirm your result. A PCR test looks for the presence of the virus' genetic material. PCR tests are highly accurate, but can take days to a week to get the results. The antigen test that you are receiving today is most accurate if you are symptomatic and within the first five days of symptoms.

Patient Signature: _____ Date: _____