RICHARD'S PHARMACY
207 Broad Ave.
Palisades Park, NJ 07650

SCREENING FORM: GROUP A STREP

(Patients fill out sections 1-3)

I. Dear Dr. _____,

Upon suspicion of FLU A+B, we have performed preliminary screening based on the CDC symptoms with the patient's consent.

_____	_____	_____	_____	_____
NAME (LAST)	NAME(FIRST)	(MIDDLE INITIAL)	(DOB)	(AGE)

_____	_____	_____	_____
(ADDRESS)	(CITY)	(STATE/ZIPCODE)	(MEDICATION ALLERGIES)

_____	_____	_____	_____
(SEX)	(PHONE NUMBER)	(PRIMARY PHYSICIAN)	(PRIMARY PHYSICIAN PHONE/FAX)

HISTORY OF CURRENT ILLNESS

II. Check ALL that describe symptoms you feel.

Group A Strep Symptoms

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

Symptoms Not Suggestive of Group A Strep

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

Actions Taken to Date: _____

SCREENING CONSENT

III. Please read the following statements and sign below on the signature line.

I have read of have had explained the information provided about the Group A Strep Screening I am about to receive. I have had the opportunity to ask questions that were answered to my satisfaction. I believe the I understand the benefits and risks of the Group A Strep Screening and ask that the Group A Strep Screening be given to me or to the person named above for whom I am authorized to make this request.

X_____ _____

Signature of person to receive Strep Screening or person authorized to make request (Parent/Guardian) (DATE)

ASSESSMENT

(Pharmacy use ONLY)

Score:

Absence of cough (1 point)
History of Fever >100.4ºF (1 point)
Presence of red/swollen tonsils (1 point)
Swollen nymph nodes (1 point)

Total Score

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

SCREENING INFORMATION

Rapid Detection of Group A Strep
BD Veritor™ System Test Device

Relative Sensitivity: 95.4%
Relative Specificity: 95.7%

Lot: _____ Expiry: _____

PHARMACOTHERAPY PLAN (Physician's Response Required for Antibiotic Therapy)

Test Result: Positive Negative RPh Signature: _____ Supportive Care recommended by pharmacist:

☐ **Initiate antibiotic therapy:**

- ☐ Amoxicillin: _____
- ☐ Cephalexin: _____
- ☐ Clarithromycin: _____
- ☐ Azithromycin: _____
- ☐ Acetaminophen: _____
- ☐ Ibuprofen: _____
- ☐ Fluids
- ☐ Other: _____

☐ **Patient to visit office/clinic**

Physician's Signature: _____ Date: _____

Disclaimer: This assessment is for screening purposes only and does not constitute a medical diagnosis.

RICHARD'S PHARMACY
207 Broad Ave
Palisades Park, NJ 07650
201-944-0863
Richardspharmacy1.com

Dear immunization patient,

If there is a change in your health status, please call the pharmacy to reschedule. Masks and gloves are required to be worn while in the pharmacy. Please call us when you arrive in the parking lot, we will instruct you when to enter the building. Upon entry to the pharmacy, we will take your temperature with a non-contact infrared forehead thermometer

Our goal has always been to deliver our services efficiently. Therefore in an effort to reduce extended waiting periods for our patients, we ask that you ***print*** the forms from OUR WEBSITE www.richardspharmacy1.com , ***fill them out and bring the completed forms with you on your scheduled appointment date.***

Your cooperation is greatly appreciated as we continue to strive for excellence in courteous, expeditious healthcare for all our patients.

Richard's Pharmacy staff