EPINEPHRINE PRESCRIBING INTAKE AND CONSENT

Name:	Date of Birth: / / Age: Gender:
Address:	City: State: Zip Code:
Phone Number:	Mobile Number:
Primary Care Provider:	Provider Phone Number:
Provider Address:	City: State: Zip Code:

PATIENT ELIGIBILITY *If any questions are unclear, please ask for assistance.*	YES	NO
1. Are you 18 years of age or older?	☐	☐
2. Are you currently experiencing symptoms suggestive of anaphylaxis? (Difficulty breathing, wheezing, swelling of face, lips, tongue, or throat, rapid heartbeat, hives or widespread rash, dizziness, fainting, or confusion, vomiting or diarrhea after allergen exposure)	☐	☐
3. Do you have a history of allergic or anaphylactic reaction (to food, medication, insect bites/stings or other), or have been diagnosed with a severe allergy by a healthcare provider? If yes, list allergies and describe the reaction:	☐	☐
4. Have you ever been hospitalized or required emergency treatment due to an allergic reaction?	☐	☐
5. Have you previously been prescribed an epinephrine auto-injector?	☐	☐

Current Medications (please list all Rx, OTC, herbal, topical, pain or allergy, supplements, vitamins, etc.):

Medical History and Current Conditions:

□ Angina	□ Diabetes	□ Kidney disease	□ Others, list all here:
□ Asthma	□ High blood pressure	□ Parkinson's disease	
□ Cardiac Arrythmias	□ Hyperthyroidism	□ Pregnant or planning pregnancy	

INFORMED CONSENT

I understand the services provided by the pharmacy are being performed for my convenience and are not a substitute for the care of a physician or hospital. As with any medical procedure, I understand it is important if I have any questions or concerns to seek advice from a primary care physician who can provide comprehensive care and consider my complete medical history.

I DO NOT have any questions about the services provided by the pharmacy. ☐

I DO have questions about the services provided by the pharmacy. ☐

I understand the use of an epinephrine autoinjector is not intended to be a substitute for medical care. Appropriate medical care following injection includes contacting emergency services (911) and making my primary care provider aware.

Yes ☐ or No ☐

I authorize the pharmacist to send information regarding my care and notification of my prescription to healthcare providers identified by me. Yes ☐ or No ☐

epinephrine prescribing. I further understand that the pharmacist is not acting as my medical provider, this service does not replace medical care and treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regard to my health needs. I agree that it is my obligation to seek medical advice, follow-up care and treatment from a medical provider if I have questions or concerns and/or to follow-up on medication provided by the pharmacy, or if my condition worsens. I have had the opportunity to ask questions about the services received at the pharmacy, the associated risks and benefits. All my questions have been answered to my satisfaction. I hereby release Giant Pharmacy and its parent, subsidiary and affiliates, and its officers, employees and agents, respectively, from any and all liability that might arise from these results on behalf of me, my heirs and personal representatives. I acknowledge I have the right to ask for a copy of the Giant Notice of Privacy Practices.

By signing below, I acknowledge that I have read and understand the information provided to me, and I consent to receive services at the pharmacy.

Patient Date of Birth (MM/DD/YYYY):_____Patient Age: _____years

_____

Patient Name (Please Print) Patient Signature Date (MM/DD/YYYY)

_____

Patient Representative (Please Print) Patient Representative Signature Date (MM/DD/YYYY)

PATIENT ASSESSMENT **PHARMACY USE ONLY SECTION**		
Patient's full name:	Date of Birth: / /	Age:
Address:	City: State:	Zip Code:
I have reviewed the eligibility questions. RPh Initials____	Date of last epinephrine prescription:	
Blood Pressure:	Weight:	

Patients who do not qualify for Epinephrine shall be referred by the pharmacist to a primary care provider or urgent/emergent treatment facility as clinically appropriate. This referral shall be documented. List reason:

Product Prescribed:

☐EpiPen® Auto-Injector or Generic Epinephrine Auto-Injector	☐0.3mg if ≥30 kg (66 lbs) Qty: _____ Refills:___ DAW:____	Inject into outer thigh, through clothing if necessary. Hold for 3 seconds. Call 911 after use.
☐Auvi-Q®	☐0.3mg if ≥30 kg (66 lbs) Qty: _____ Refills:___ DAW:____	Inject into outer thigh, through clothing if necessary. Hold for 2 seconds. Follow voice instructions. Call 911 after use.
☐Epinephrine Injection, authorized generic of Adrenaclick®	☐0.3mg if ≥30 kg (66 lbs) Qty: _____ Refills:___ DAW:____	Inject into outer thigh, through clothing if necessary. Hold for 10 seconds. Check red tip. Call 911 after use.

Date: _____

Pharmacist Name:_____Pharmacist Signature: _____NPI:_____

Pharmacy Address: Pharmacy Phone #:

COUNSELING, *Counsel according to the requirements of the BOP Protocol*

☐ Effectiveness

☐ dverse Effects

☐ Storage conditions and shelf-life

☐ How to properly recognize and manage anaphylaxis including proper administration

☐ A recommendation that 911 be called if epinephrine is administered

☐ Notify the Primary Care Provider Or Referral to a primary care provider

☐ Any other information deemed necessary in the professional judgment of the pharmacist