



Minor Ailments and Contraception Service (MACS) Form

Name of patient	Patient phone number	Personal Health Number	Informed consent? <input type="checkbox"/> Yes
-----------------	----------------------	------------------------	---

Minor ailment of concern/ contraception:

<input type="checkbox"/> Contraception	<input type="checkbox"/> Dysmenorrhea	<input type="checkbox"/> Headache	<input type="checkbox"/> Shingles
<input type="checkbox"/> Acne	<input type="checkbox"/> Dyspepsia	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Nicotine dependence
<input type="checkbox"/> Allergic rhinitis	<input type="checkbox"/> Fungal infections	<input type="checkbox"/> Herpes labialis	<input type="checkbox"/> Threadworms or pinworms
<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Onychomycosis	<input type="checkbox"/> Impetigo	<input type="checkbox"/> Urinary tract infection
<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Tinea corporis infection	<input type="checkbox"/> Oral ulcers	<input type="checkbox"/> Urticaria, including insect bites
<input type="checkbox"/> allergic/contact	<input type="checkbox"/> Tinea cruris infection	<input type="checkbox"/> Oropharyngeal candidiasis	<input type="checkbox"/> Vaginal candidiasis
<input type="checkbox"/> atopic	<input type="checkbox"/> Tinea pedis infection	<input type="checkbox"/> Musculoskeletal pain	
<input type="checkbox"/> diaper rash	<input type="checkbox"/> Gastroesophageal reflux disease		
<input type="checkbox"/> seborrheic			

PATIENT ASSESSMENT	PharmaNet checked? <input type="checkbox"/> Yes	Patient eligible? <input type="checkbox"/> Yes
---------------------------	---	--

Patient symptoms and signs:

Assessment of relevant medical history and medications:

Diagnosis: _____

RECOMMENDATIONS (may include medication(s), self-care strategies, and/or advice to seek medical attention from physician or other healthcare professionals)

Prescription issued? Yes No

Advised to seek medical attention from another healthcare professional? Yes; advised to see: _____ No

Details of prescription and/or other recommendations, with rationale:

MONITORING and FOLLOW-UP PLAN

PROVIDERS NOTIFIED (if applicable)

Primary care provider (name): _____ Date and method notified: _____

Other health care providers: _____ Date and method notified: _____

PHARMACY/PHARMACIST INFORMATION

Pharmacy name: _____ Pharmacy address: _____

Pharmacy phone number: _____

Print name of pharmacist and licence number

Rph

Signature of pharmacist

Date signed