Ministry of Health

# PHARMANET
# Patient Consent to Access PharmaNet

The Province of British Columbia has established the provincial pharmacy network and database known as "PharmaNet" pursuant to section 37 of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act,* R.S.B.C. 1996, c. 363, and which may be continued pursuant to section 13 of the *Pharmacy Operations and Drugs Schedule Act,* S.B.C., 2003, c. 77 should it be proclaimed in force during the term of this Agreement.

I, _____ , authorize _____ Script Care Pharmacy _____
<div align="center"><em>Name of Patient (print)</em>              <em>Name of Pharmacy (print)</em></div>

to access my personal health information contained within PharmaNet for the purpose of providing therapeutic treatment or care to me, or for the purpose of monitoring drug use by me.

I understand that withdrawal of this consent must be in writing and delivered to the above-named pharmacy.

Executed at _____ , this _____ day of _____ , 20____ .

SIGNED AND DELIVERED by )
)
)
)
_____ )
*Patient (print)* )
)
in the presence of: )
)
)
)
_____ )  _____
*Witness (signature)* )  *Patient (signature)*
)
)
_____ )
*Witness (print)* )
)
)
_____ )
*(Dated)* )

**TurningPoint**

# STANDING ORDER MEDICATIONS AUTHORIZATION

**CLIENT NAME** _____  Date _____  TP Site_____

**Medication Allergies:** _____

*Please indicate whether or not each of these medications can be administered to the above client by initialing in the appropriate box.*                                                                                      **Physician Initials**

| Indication | Medication & Dosage | Instructions | Yes | No |
|---|---|---|---|---|
| **PAIN**<br>Headache, Mild Muscle or Joint Pain | **Ibuprofen (Advil)**<br>200mg - 1-2 tablets every 4-6 hrs with food<br>**Acetaminophen (Tylenol) extra strength**<br>500mg every 4 -6 hrs; max: 4000mg/24 hrs<br>**ASA (Aspirin)**<br>325mg every 4-6 hrs | 1. Give for 48 hrs only for any complaint<br>2. If persistent, contact physician | | |
| **FEVER**<br>Temp. above 37.5 C | **Acetaminophen extra strength**<br>500mg every 4-6 hrs; max: 4000mg/24 hrs | 1. If fever increases, contact physician<br>. If fever persists beyond 24 hrs, contact physician | | |
| **COUGH** | **Buckleys**  5–10 ml (1-2 tsp)  every  3-4 hrs<br>**Cold Relief Combo**  every 12 hrs<br>**Cough Lozenges**  as needed | Give for 48 hrs<br>If persistent, contact physician | | |
| **SORE THROAT** | **Cepacol / Fisherman's Friend Lozenges**<br>1 every 3 hrs | . Give for 48 hrs<br>2. If persistent, contact physician | | |
| **NAUSEA / VOMITING**<br>Lasting more than 6 hrs | **Dimenhydrinate (Gravol)**  50 mg every 6 hrs | Give for 48 hrs<br>If persistent,  contact physician | | |
| **INDIGESTION**<br>Complaints of burning epi-gastric pain | **Calcium Carbonate (Tums)**  1 or 2  Max 8/day<br>**Aluminum Hydroxide/Magnesium Hydroxide (Diovol)**<br>10-20ml (2-4 tsp) up to 4x/day max:16 tsp/day<br>**Bismuth Subsalicylate (Pepto Bismol)** 15-30ml (1-2 tbsp)  4 x day | .   Give for 24 hrs<br>If persistent, contact physician | | |
| **DIARRHEA**<br>More than one watery bowel movement | **Bismuth Subsalicylate (Kaopectate)**  30–60 ml (2-4 tbsp) after each loose bowel movement<br>**Loperamide (Imodium)**  2 mg - 2 caplets, then 1 after each loose bowel movement.  Max 8/day | Give for 24 hrs only<br>Contact physician if condition worsens or persists | | |
| **CONSTIPATION** | **Prune Juice**  1 cup every 6 hrs for 24 hrs<br>**Sennosides**  8.6 mg - 1-3 tablets 1xday for 48 hrs | Contact physician if condition worsens or persists | | |
| **CUTS, BITES** | **Polysporin ointment (or equivalent)**<br>Apply to the affected area(s) as needed<br>**Hydrogen Peroxide**  10 vol 3%        "<br>**Rubbing Alcohol**  70% v/v            " | Contact physician if worsens | | |
| **ALLERGIC REACTIONS**<br>Itching, Sneezing, Runny Nose/Congestion Rash, Hives | **Loratadine (Claritin) 24 hr**  10 mg<br>1 tablet 1xday as needed<br><br>**Calamine Lotion** – apply as needed | Contact physician if no improvement after 4 days | | |

**Physician Name**        _____  **CPSID #** _____

**Physician Signature** _____  **Date**_____

*This Standing Order Medications Authorization is in effect for one year from the date signed*

***Please fax completed form to Turning Point Fax Number:*** _____

# VITAMINS AND SUPPLEMENTS AUTHORIZATION

**CLIENT NAME** _____ Date _____ TP Site _____

| Supplement & Strength | Instructions | Continue | D/C | Qty Authorized |
|---|---|---|---|---|
| *e.g. Vitamin D 1000 IU* | *Take one tablet by mouth daily in the morning* | √ | | *3 months (90 tablets)* |
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| | | | | |

Physician Name        _____ CPSID # _____

Physician Signature _____ Date_____

***Please fax completed form to Turning Point Fax Number:*** _____

*Turning Point Staff: Fax completed form to Pharmacy & file with Client's Medication Administration Record (MAR)*