

WALKING IN CONSUMERS SHOES: SEM 2 DATA COLLECTION FORM

SCENARIO TEN	VERSION EIGHT
Product requested	VENTOLIN® [Salbutamol]
Who is the patient?	Self
How long:	Had asthma since you were a child
Actual Symptoms – what are they?	Wheezy during the day
Treatment for this or any other conditions?	Take puffer (Ventolin®) three or four times a day when you feel wheezy. Helps for a little while. If asked you are not coughing at night.
Additional Info	Think you only have mild asthma that is under control. Do not realise that you are overusing your puffer. Do have a Seretide® [fluticasone propionate/salmeterol] inhaler somewhere, not using it at the moment. No asthma management plan. Haven't discussed asthma with a doctor for a year or so.
Have you used it before?	Yes.
SCENARIO ANGLE	Refer to medical practitioner - poorly controlled asthma, no preventer use, and no asthma management plan.

PHARMACY NAME AND ID	
STUDENT NAME AND ID	
VISIT DATE	
VISIT TIME	

WHO SERVED YOU?		
Pharmacy assistant?	Y	N
Pharmacist?	Y	N
Did the assistant ask the pharmacist for advice?	Y	N
Did the assistant refer the customer to the pharmacist?	Y	N
Notes:		

STUDENT FEEDBACK FORM (SCENARIO TEN)

WHAT: DID THEY FIND OUT?				
W: Who the medicine was for?				
Self	Y	N	Part	N/A
H: How long you'd had the symptoms?				
Years – diagnosed with asthma as a child	Y	N	Part	N/A
A: About the actual symptoms?				
Wheezy during day	Y	N	Part	N/A
T: About treatment for this or any other condition?				
What treatment you'd already tried? (Regular salbutamol use)	Y	N	Part	N/A
Was the treatment successful? (Moderately)	Y	N	Part	N/A
If you take any other medication? (Have Seretide® – don't use it)	Y	N	Part	N/A
If you have any other medical conditions? (None)	Y	N	Part	N/A
STOP: DID THEY STOP AND?				
Consider the issue? (Poorly controlled asthma/no asthma management plan)	Y	N	Part	N/A
GO: DID THEY?				
Address the issue?				
Refer to GP for review	Y	N	Part	N/A
Suggest a review of asthma management plan	Y	N	Part	N/A
Other? (please record here)				
Recommend/provide any products ?	Y	N	Part	N/A
Record Product Name/s and Strength:				
For each product they recommended/provided, did they:				
Recommend an appropriate dose and dosage interval?	Y	N	Part	N/A
Recommend how long to use the product for?	Y	N	Part	N/A
Provide relevant verbal advice on asthma management?	Y	N	Part	N/A
Record type of Verbal Advice				
Provide relevant written advice ? (please attach to this form)	Y	N	Part	N/A
Provide appropriate follow-on advice ?				
Refer you to the doctor for the presenting symptoms?	Y	N	Part	N/A
Tell the customer when to return to the pharmacy?	Y	N	Part	N/A
Tell the customer when to visit the doctor (e.g. if it persists)?	Y	N	Part	N/A
Record any specific Follow-on advice (i.e. advice on WHAT to do next and WHEN)				
OVERALL				
Do you think the visit had an appropriate outcome ?	Y	N	Part	N/A
Do you think they established a good rapport with you?	Y	N	Part	N/A
How would you rate the information they provided?	Good	Adequate	Not Adequate	
Do you have any comments?				

COUNSELLOR FEEDBACK FORM (SCENARIO TEN)

WHAT: DID YOU FIND OUT?				
W: Who the medicine was for?				
Self	Y	N	Part	N/A
H: How long they'd had the symptoms?				
Years – diagnosed with asthma as a child	Y	N	Part	N/A
A: About the actual symptoms?				
Wheezy during day	Y	N	Part	N/A
T: About treatment for this or any other condition?				
What treatment they'd already tried? (Regular salbutamol use)	Y	N	Part	N/A
Was the treatment successful? (Moderately)	Y	N	Part	N/A
If they take any other medication? (Have Seretide® – don't use it)	Y	N	Part	N/A
If they have any other medical conditions? (None)	Y	N	Part	N/A
STOP: DID YOU STOP AND?				
Consider the issue? (Poorly controlled asthma/no asthma management plan)	Y	N	Part	N/A
GO: DID YOU?				
Address the issue?				
Refer to GP for review	Y	N	Part	N/A
Suggest a review of asthma management plan	Y	N	Part	N/A
Other? (please record here)				
Recommend/provide any products ?	Y	N	Part	N/A
Record Product Name/s and Strength:				
For each product you provided, did you:				
Recommend an appropriate dose and dosage interval?	Y	N	Part	N/A
Recommend how long to use the product for?	Y	N	Part	N/A
Provide relevant verbal advice on asthma management?	Y	N	Part	N/A
Record type of Verbal Advice				
Provide relevant written advice ? (please attach to this form)	Y	N	Part	N/A
Provide appropriate follow-on advice ?				
Refer the customer to the doctor for the presenting symptoms?	Y	N	Part	N/A
Tell the customer when to return to you?	Y	N	Part	N/A
Tell the customer when to visit the doctor (e.g. if it persists)?	Y	N	Part	N/A
Record any specific Follow-on advice (i.e. advice on WHAT to do next and WHEN)				
OVERALL				
Do you think the visit had an appropriate outcome ?	Y	N	Part	N/A
Do you think you established a good rapport with the customer?	Y	N	Part	N/A
How would you rate the information you provided?	Good	Adequate	Not Adequate	
Do you have any comments?				