**FeNO Toolkit for Community Pharmacies**

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**Appointment Materials**

**Your company logo**

Your Pharmacy

Address

Address

Phone:

Fax:

Date:

To:

Fax:

**Patient Name:**

**DOB:**

**Background: Our mutual patient participated in an asthma standard of care appointment, I have attached the visit summary.**

**If you have any other patients that you feel may benefit, feel free to refer them. Currently the study is closed to patients that use tobacco products. Patients are not required to fill prescriptions at the (Insert Your Pharmacy Name) to participate in the study.**

|  |  |
| --- | --- |
| **Pharmacist Recommendation** | **Prescriber Comment** (must send new prescriptions for any changes) |
|  **Please send a new prescription for:****I am recommending initiating the following medications:** |  |

Please consider the recommendations and fax back this form with your comments and **any new prescriptions**. *Thank you!*

Sincerely,

*Sign Here*

**Medication Therapy Management Services Documentation**

**Date:**  **Patient Name:**  **Date of Birth:**

**CC:**

**Problem List:**

**Subjective:**

**HPI:**

**PMH:**

**FH:**

*Allergies:*

*Environmental:*

*Lifestyle:*

Alcohol:

Tobacco:

Caffeine:

Diet:

Exercise:

Adherence:

Triggers:

**Objective:**

ACT: (A score less than 19 indicates poor asthma control)
FeNO: (<25 ppb indicates low levels of inflammation in lungs)

Medications:

**Assessment:**

**Plan & Recommendation(s):**

**Follow-up** at pharmacy with pharmacist in 3 months near

***Pharmacist Signs***

**FeNO CMRA Outline
Initial Visit**

WELCOME!

Goals

1. To have an accurate record of all your medications, over-the-counter medications, supplements, and herbals.
2. Understand HOW and WHY you are taking your medications
3. Understand how to MONITOR and MANAGE your drug therapy
4. Learn how to OVERCOME any side effects and cost issues with your medications.

PLAN OF ACTION

1. What are your goals and concerns today?

2. Gather background information

a. Allergies:

b. Date of Diagnosis:

c. SH

1. EtOH
2. Tobacco
3. Caffeine
4. Diet

d. PMH:

e. FH:

f. Exercise:

g. Triggers for disease(s):

3. Go over medication list

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication** | **Directions** | **Technique** | **Adherence** | **Storage** | **Cleaning** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

4. Review Asthma Symptoms and control: Copy of Asthma Toolkit

5. ACT Score/FeNO

6. Immunization record

7. Wrap-up and summarize

**FeNO CMRA Outline
Follow-Up Visit**

WELCOME!

Goals

1. To have an accurate record of all your medications, over-the-counter medications, supplements, and herbals.
2. Understand HOW and WHY you are taking your medications
3. Understand how to MONITOR and MANAGE your drug therapy
4. Learn how to OVERCOME any side effects and cost issues with your medications.

PLAN OF ACTION

1. What are your goals and concerns today?

2. Gather background information

a. Allergies

b. SH

1. EtOH
2. Tobacco
3. Caffeine
4. Diet

c. Exercise

d. Triggers for disease(s)

3. Go over medication list

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication** | **Directions** | **Technique** | **Adherence** | **Storage** | **Cleaning** |
|  |  |  |   |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

4. Review Asthma Symptoms and control: Copy of Asthma Toolkit

5. ACT Score/FeNO

6. Immunization record

7. Wrap-up and summarize

**Patient Satisfaction Survey: Comprehensive Medication Review & Assessment FeNO**

Each of the following questions relate to your meeting with a pharmacist to review your medications. Please answer each question to the best of your ability. Please place an “X” in the box that corresponds to your answer to each question using the scale: poor, fair, good, very good and excellent.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Poor** | **Fair** | **Good** | **Very Good** | **Excellent** |
| 1. How would you rate your overall satisfaction with your meeting with the pharmacist today?
 |  |  |  |  |  |
| 1. How would you rate the pharmacist’s ability to help you prevent problems due to your medications?
 |  |  |  |  |  |
| 1. How would you rate the pharmacist’s ability to provide you with information about your medications?
 |  |  |  |  |  |
| 1. How would you rate the pharmacist’s ability to provide you information about your health?
 |  |  |  |  |  |
| 1. How would you rate the pharmacist’s knowledge?
 |  |  |  |  |  |
| 1. How would you rate the privacy of the pharmacy?
 |  |  |  |  |  |
| 1. How would you rate the pharmacist’s ability to answer your questions about your medication?
 |  |  |  |  |  |
| 1. How would you rate the pharmacist’s ability to consider your feelings and preferences when changes to your medications were suggested by the pharmacist?
 |  |  |  |  |  |
| 1. How would you rate the pharmacist’s ability to be clear when explaining any suggested changes to your medications?
 |  |  |  |  |  |
| 1. Rate the overall care you received from the pharmacist today.
 |  |  |  |  |  |
| 1. How would you rate your satisfaction with discussing FeNO results with your pharmacist?
 |  |  |  |  |  |

**Any additional comments regarding this service?­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marketing Materials**

**FeNO Radio Advertisement Script**

Do you or someone you know suffer from asthma? Ever wonder if any of those asthma devices that your doctor makes you take are even working? Well you’re in luck because **Pharmacy Name** is here to help! Stop into **Pharmacy Name** at **Pharmacy Address** or call us at **Phone Number** and ask our knowledgeable pharmacy staff if you qualify for our asthma services. Why? Because your breathing is important to you and you are important to us. So what are you waiting for, contact us today!

🙞 Do you or someone you know suffer from 🙞



Absolutely free, 15-30 minute face-to-face meeting with a pharmacist

* Optimized inhaler dosing
* Control medications costs
* Check inhaler technique
* Manage related conditions that contribute to asthma
	+ Allergies
	+ Heart burn

🙞 Do you or someone you know suffer from 🙞



Then stop in or call **Your Pharmacy Name** and ask our knowledgeable pharmacy staff about our asthma study – you may be eligible and don’t even have to be a regular patient of ours to qualify!



Address

Address Open Monday – Friday 9am-6pm
Phone Number Sunday 9am-1pm

