THE UNIVERSITY OF BRITISH COLUMBIA
Pharmacists Clinic
Faculty of Pharmaceutical Sciences

Our Practice

By pharmacists for pharmacists.

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Feature Article

Onboarding Patients with Intake Forms

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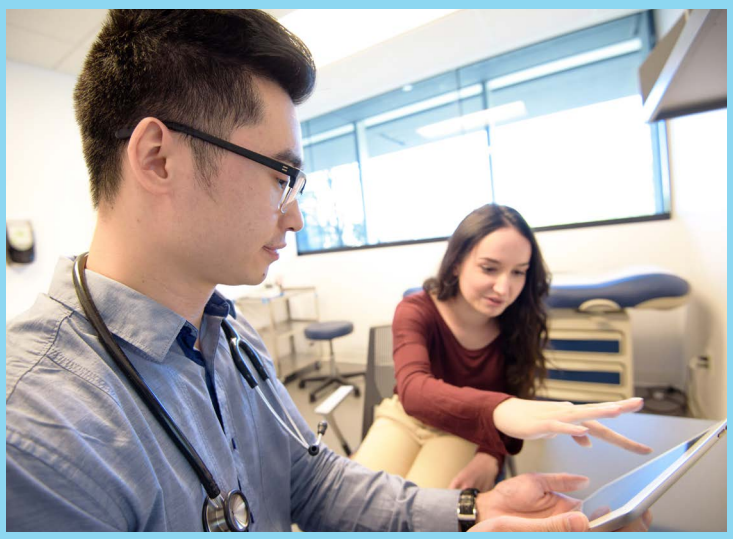

As a patient, you have likely found yourself in a waiting room filling out an intake form. It may have been your first visit with a specialist, or a follow-up appointment with your massage therapist. Intake forms are commonplace in health care and a valuable communication tool where vital information is shared. Whether you are in the early stages of, or have a well-established clinical practice in a drugstore, clinic or other care setting, intake forms are a valuable tool. Here is how we developed and use intake forms at the UBC Pharmacists Clinic.

Step 1: Decide what information you need.

Most patients we see have multiple comorbid health conditions, so identifying and prioritizing drug therapy problems with limited time is a challenge. We first thought that implementing detailed, information-heavy intake forms would make better use of our consultation time, but this was not the case. We now ask most patients only a few key questions up front, and use the answers to guide our discussion with the patient.

Step 2: Start with a small set of basic questions.

Our general intake form consists of four questions:

1. What is your name and your usual pharmacy? *(for intra-professional collaboration)*
2. What is your overall health today? Rate on a scale of one to ten.
3. What are your top four health concerns? List in order of importance.
4. Is there anything else you think is important for us to know?

Step 3: Try it with patients and get feedback.

When we first implemented a more detailed intake form, we discovered that the form was neither facilitating the flow of conversation or saving time. Questions on the form often required lengthy answers, sometimes with complex histories, that inevitably necessitated further discussion during the consult. This prompted us to switch to a short form, which has received positive patient and pharmacist feedback. Patients report greater self-awareness of health issues and feel that these are made a priority. Their thoughts are also more organized. From a pharmacist perspective, the use of this form has enabled more efficient history taking and an improved ability to follow a logical flow during the consultation.

Step 4: Modify forms for improved workflow efficiency and clinical effectiveness.

For our patients with headaches and chronic pain, we found we needed to collect more historical details up-front. We now have two additional intake forms specifically for these patients. If we do not know why a patient is coming in for a consultation, we ask them so they get the correct intake form. The headache and chronic pain forms request specific types of patient information such as a visual description of pain, pain ratings, pain triggers, and screening for other comorbid conditions such as mood and sleep disorders.

Our forms are available here for anyone to modify and use. We have fully integrated intake forms into our practice and cannot imagine working without them now. How can intake forms help you in your practice?

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Case Study

Pharmacotherapy for tremor – essential or extraneous?

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A 79-year-old female self-refers to the clinic for a general medication review. Current medical conditions and medications: insomnia (zopiclone 7.5mg PRN – using <1dose per month), hypertension (hydrochlorothiazide 25 mg daily and amlodipine 5 mg daily, BP 154/86 mmHg on exam), and osteoarthritis (naproxen 220 mg PRN and acetaminophen 500 mg PRN). She takes self-prescribed vitamin C and cod liver oil. The patient lives independently with her husband. On exam, a bilateral arm and head tremor is noted. When questioned the patient reports experiencing "shakiness" in her head, arms and voice for at least 10 years, and often feels embarrassed in social situations. Recommendations from the first appointment included optimizing acetaminophen for pain, initiating a sleep diary and sleep hygiene measures and stopping vitamin C and cod liver oil. She was referred to her family doctor for discussion of tremor. Six months later, the patient returns after seeing a neurologist who diagnosed her with essential tremor and started propranolol. Propranolol provided satisfactory reduction in arm and head tremor however, she stopped after several weeks due to fatigue with escalating doses (maximal dose reached = 80 mg BID). Neurology follow-up for onabotulinum toxin for vocal tremor was pending.

Table 1: Therapeutic alternatives considered for our patient* [1,2,3,4]

	Typical dose range	Target symptom	General Cautions	Considerations
Propranolol	60-320mg/day LA 80-320 mg/day Note 60-240mg adequate in most responders	Most effective for limb tremor	cardiac conduction disorders, asthma	Likely as effective as primidone
Primidone	Up to 750 mg/day Stop if no benefit at 250 mg	Most effective for limb tremor	elderly, mood disorders, concomitant sedative use, falls risk	-Likely as effective as propranolol -Slow titration required to minimize adverse effects -Dose reduction in renal impairment
Topiramate	Up to 400 mg/day	Likely some benefit for limb tremor, motor task performance, functional disability	mood disorders, elderly	-High discontinuation rates due to adverse effects (nausea, paresthesias, taste changes, concentration difficulty) -No head-to-head comparisons with other agents -Dose reduction in renal impairment
Onabotulinum toxin A injection	-hand tremor: 50-100 units/arm -head tremor: 40-400 units -voice tremor: 0.6-15 units Repeated PRN	-Modest benefit for limb tremor -Likely most useful for head and voice tremor	-Dose dependent muscle weakness, -concern re. breathiness, hoarseness, swallowing difficulties (if used for head/vocal tremor)	-Reserve for medically refractory cases -Costly

**Although many other medications have been studied for essential tremor, best available evidence does not support their use as first line options.*
LA = long-acting

Essential tremor is the most common of all movement disorders with an estimated worldwide prevalence of 0.9-2.2%. Onset is variable, but typically occurs after age 50. Although heterogeneous in presentation, clinical features include a progressive, involuntary action tremor, most commonly affecting the hands, arms and voice. Tremor may be exacerbated by anxiety and improved with rest and alcohol. Drug causes of tremor such as stimulants, beta-agonists and neuroleptics should be ruled out. There is no cure for essential tremor however, treatment may be offered with the goals of improving function and reducing social stigma. Approximately 30-50% of patients will not respond to first line agents and within responders, symptomatic benefit tends to decline overtime. Treatment may be

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continuous or as needed depending on functional impact and patient preference.[1,2] Viable pharmacologic alternatives for continuous treatment specific to this patient were reviewed and are summarized in Table 1. Treatment principles include starting with a low dose and titrating slowly with a low threshold for tapering ineffective medications. Small trials support an additive benefit of propranolol and primidone, although this combination may be poorly tolerated especially in the elderly. Of note, studies of pharmacotherapy for essential tremor are generally of poor quality with reporting gaps and use of variable drug regimens, short follow-up and lack of meaningful clinical outcomes.[1,2,3,4]

Considering the best available evidence and patient preference, a re-trial of propranolol was agreed upon starting at 20 mg daily and not to exceed 40 mg BID (this was previously tolerated with some benefit). Depending on her response, future consideration may be given to a cautious trial of topiramate. The patient elected not to pursue onabotulinum toxin treatment for vocal tremor due to lack of convincing data for benefit and cost concerns.

References

1. Deuschl G, Raethjen J, Hellriegel H, Elble R. Treatment of patients with essential tremor. Lancet Neurol. 2011 Feb;10(2):148-61.
2. Zesiewicz TA, Elble RJ, Louis ED, Gronseth GS, Ondo WG, Dewey RB Jr, et al. Evidence-based guideline update: Treatment of essential tremor: Report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology. 2011;77(19):1752-1755.
3. Zappia M, Albanese A, Bruno E, Colosimo C, Filippini G, Martinelli P et al. Treatment of essential tremor: a systematic review of evidence and recommendations from the Italian Movement Disorders Association. J Neurol. 2013 Mar;260(3):714-40.
4. Chang KH, Wang SH, Chi CC. Medicine (Baltimore). Efficacy and Safety of Topiramate for Essential Tremor A Meta-Analysis of Randomized Controlled Trials. 2015 Oct; 94(43): e1809.

Correction – We would like to issue the following corrections to Issue 1, Table 1: Numbers needed to treat should be disregarded given insufficient data reported to allow for accurate calculation. Duration of headache days reported by Peikert et al was not statistically significant.

Note: This case study has been peer reviewed and qualifies as a non-accredited CE learning activity within the annual professional development requirement for licensure by the College of Pharmacists of BC.

Your Responsibility

Health care professionals are required to assess each case based on the patient's unique circumstances in consultation with the patient and their care team. The recommendations in this case are based on the views of our clinicians after careful consideration of the best available evidence and needs of the patient. If you would like to discuss one of your patients with us please contact the Clinic team.

Clinical FYI

This issue we're sharing some of the free, online clinical resources that we frequently use for staying current.

EBM Focus (*Dynamed*)	Weekly	http://www.dynamed.com/home/about/ebm-journal/ebm-focus
NICE Newsletters/Update for primary care	Monthly	https://www.nice.org.uk/news/nice-newsletters-and-alerts
Therapeutics Letter (*Therapeutics Initiative*)	Every two months	http://www.ti.ubc.ca/therapeutics-letter
This Changed my Practice (*UBC Family Med*)	Every two weeks	http://thischangedmypractice.com
Tools for Practice (*Alberta College of Family Physicians*)	Every two weeks	https://www.acfp.ca/tools-for-practice

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