

Appalachian College of Pharmacy
Patient Self – Medication Consultation/Intervention



Appalachian College of Pharmacy
Patient Self – Treatment Consultation Form

Student:
Rotation:
Site:
Preceptor:
Date:

Patient Initials:

1. Describe the symptoms and the symptom time frame which led this patient to desire OTC therapy:

2. What other disease states, conditions, or medications the patient was taking influenced your recommendation?

3. Was the patient referred to a primary care provider? YES NO
List the reasons for this decision:

4. If you recommended an OTC product, please detail your recommendation, the method by which the patient should monitor for efficacy or adverse effects, and any additional advice you gave the patient.

Preceptor signature:

Date: