Audit of Self-Administered Injectable Adrenaline Prescription in Primary Care (www.guideline-audit.com) : Individual patient data sheet

INSTRUCTIONS: please enter the data for each patient identified on the summary sheet. Individual patient data can be entered onto this sheet first and then transferred online onto the guideline website using the practice logon details at www.guideline-audit.com

i) Patient confidential identifier for use online (eg 1, 2, 3 etc): ………………………

ii) Date of Audit: ……. / ……. / ………….. (dd/mm/yyyy)

iii) Date of last consultation (GP or hospital) for review of allergic problem or anaphylaxis:

……. / ……. / ………….. (dd/mm/yyyy)

iv) Date of Birth: ……. / ……. / ………….. (dd/mm/yyyy) **Or** age in months: ………………
(The online entry system converts DOB into age in months)

v) Gender: Male / Female / Other

vi) Ethnicity: tick one

White		**Mixed**		**Asian or Asian British**		**Black or Black British**		**Chinese or other ethnic group**	
British		White and Black Caribbean		Indian		Caribbean		Chinese	
Irish		White and Black African		Pakistani		African		Other ethnic group	
Other White		White and Asian		Bangladeshi		Other Black		**Patient Refused information**	
		Other Mixed		Other Asian					

vii) Type and dose of medication: (Tick the **one** that applies and enter the date of the last prescription and the number of devices to be issued)

Type of autoinjector	0.15mg	0.3mg	Date last prescribed dd/mm/yyyy	Number of devices prescribed
Anapen			……/……./……..	1 / 2 / 3 / 4 ; other ……
EpiPen			……/……./……..	1 / 2 / 3 / 4 ; other ……
Fastject			……/……./……..	1 / 2 / 3 / 4 ; other ……
Twinject			……/……./……..	1 / 2 / 3 / 4 ; other ……
Ana-Kit			……/……./……..	1 / 2 / 3 / 4 ; other ……

viii) Patients weight at time of prescription: ……………………………………………..… under 30 kg / over 30 kg

ix) Is there a diagnosis of anaphylaxis in the patients record?..Yes / No / Unclear

x) Is there a diagnosis of asthma in the patients record?..Yes / No / Unclear

xi) Is there a record of specific symptoms of an anaphylactic reaction requiring injectable adrenaline (Tick all that apply in this patient):

Airway blockage/voice change		Dizziness, collapse or unconsciousness		Sudden onset of symptoms		Other symptoms:	
Terrible chest tightness		Skin and mucosal changes - flushing, urticaria, angioedema		gastrointestinal symptoms – vomiting, abdo pain, incontinence		No symptoms recorded	

xii) Was exposure to a specific trigger or cause for the reaction identified?
If so what was this (Tick all that apply):

Food				Other Triggers		Drugs/contrast media	
Fish		Peanut		Stings		Anaesthetic	
Eggs		Other nuts		Latex		Antibiotic	
Fruit		Yeast		Dye		Other drugs	
Dairy		Other food		Other trigger		Contrast media	

xiii) Was this patient seen by an allergy expert/specialist? ………………………………………. Yes / No / Don't Know

- If **Yes,** Did the specialist confirm the diagnosis of anaphylaxis?
………………………………………………Yes / No / Not sure

Did the specialist confirm a diagnosis of IgE mediated allergy?
………………………………………………Yes / No / Not sure

Did the specialist confirm the need for prescribing injectable adrenaline?
………………………………………………Yes / No / Not sure

- If **No,** Did the specialist make an alternate diagnosis to that of anaphylaxis? …………………………...Yes / No

- If **Yes,** was this Oral Allergy Syndrome? ………………………………………………………………..Yes / No

Or Other diagnosis: ………………………………………………………………………….

xiv) Is there a record that the patient (or parent or representative)
was taught how to use the device? ……………………………………………..……Yes / no / not sure

- If **Yes,** Most recent date last demonstrated : ……. / ……. / ………….. (dd/mm/yyyy)

- Where was this done? In the GP Surgery / Specialist Clinic / Both / Don't know

By using: a demonstration device? : ………………………………………………………Yes / No / not sure

- A Video (in surgery or online)? : …………………………………………………..Yes / No / Not sure
- Or Other : ……………………….……………………………………………………………………….

xv) Is there a record that the patient was able to demonstrate their ability to use the device?
…………………………………………………..………………………………..………Yes / No / Not sure

- If **Yes,** date demonstrated……. / ……. / ………….. (dd/mm/yyyy)

xvi) Has this patient been issued with a written self-management plan for treating anaphylaxis?
………………………………………………………………………………………….……..Yes / No / Don't know

- If **Yes,** when was this last revised: ……. / ……. / ………….. (dd/mm/yyyy)
- Where was this provided?
…………………………………………….In the GP Surgery / Specialist Clinic / Both / Don't know

xvii) Has this patient ever had to use/ be administered injectable adrenaline?

……………………...………… …..Yes/ No / Don't know

- If **Yes,** was this administered by: …………………Self / Other (doctor/paramedic/parent) / Don't know