

**Audit of Self-Administered Injectable Adrenaline Prescription in Primary Care**  
**([www.guideline-audit.com](http://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](http://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	<input type="checkbox"/>	Peanut	<input type="checkbox"/>	Stings	<input type="checkbox"/>
Eggs	<input type="checkbox"/>	Other nuts	<input type="checkbox"/>	Latex	<input type="checkbox"/>
Fruit	<input type="checkbox"/>	Yeast	<input type="checkbox"/>	Dye	<input type="checkbox"/>
Dairy	<input type="checkbox"/>	Other food	<input type="checkbox"/>	Other trigger	<input type="checkbox"/>
				Contrast media	<input type="checkbox"/>

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

o A Video (in surgery or online)? : .....Yes / No / Not sure

o 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