

Year 2 - Practical Notes

Pharmacotherapeutics

24 complete practical and activity notes. The page counts below exclude the promotion page. Use the PDF bookmarks to move between practicals.

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SOAP Case Study - Hypertension

Experiment 1 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional hypertension case.

Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

Fictional Case and SOAP Guide

Section	Model teaching content
S - history	A fictional 52-year-old reports irregular use of the prescribed antihypertensive and no current symptoms.
O - supplied findings	Supplied seated readings on separate visits: 150/94 and 152/92 mmHg; medicine and renal/electrolyte details need confirmation.
A - assessment	The supplied pattern suggests above-target blood pressure with an adherence problem; review measurement quality and patient-specific goals.
P - professional plan	Confirm the actual prescription and barriers; arrange clinician review of repeated readings, relevant tests and the long-term plan.

Counselling and Monitoring

Counselling

Explain regular prescribed use, correct measurement, feasible activity and reduced excess salt.

Monitoring

Repeated BP, adherence, symptoms and drug-specific renal/electrolyte checks.

Urgent Review

Chest pain, severe breathlessness, acute neurological symptoms or other signs of an acute emergency.

Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

Practice Scenario

Original fictional case for discussion only.

Pharmacotherapeutics

Activity Procedure

1. Extract S and O

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

3. Prioritise

Check emergency/referral needs before routine counselling.

4. Plan

State the authorised review, counselling and monitoring steps.

5. Write

Complete the blank SOAP record and a concise handover using the model guide.

Record and Observations

SOAP field	Student record
S - subjective history	_____
O - objective information	_____
A - assessment / priorities	_____
P - actions / review	_____
Monitoring / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

Viva Questions and Answers

1. What belongs in S?

The person's reported symptoms, concerns and relevant history.

2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

SOAP Case Study - Angina

Experiment 2 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional angina case.

Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

Fictional Case and SOAP Guide

Section	Model teaching content
S - history	A fictional 60-year-old with diagnosed stable angina describes usual exertional discomfort but asks about a newly different episode.
O - supplied findings	A supplied cardiology record documents previous stable disease; current symptom duration and response to the prescribed plan are unknown.
A - assessment	A changed chest-pain pattern can represent acute coronary disease and cannot be assumed to be routine stable angina.
P - professional plan	Assess immediate symptoms and activate urgent/emergency evaluation for ongoing, new or worsening pain; use the existing clinician-approved emergency plan.

Counselling and Monitoring

Counselling

Explain adherence, risk-factor management and knowing the prescribed emergency instructions.

Monitoring

Episode pattern, functional capacity, adherence and medicine adverse effects after clinical review.

Urgent Review

New, prolonged or rest pain, sweating, collapse or breathing difficulty.

Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

Practice Scenario

Original fictional case for discussion only.

Pharmacotherapeutics

Activity Procedure

1. Extract S and O

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

3. Prioritise

Check emergency/referral needs before routine counselling.

4. Plan

State the authorised review, counselling and monitoring steps.

5. Write

Complete the blank SOAP record and a concise handover using the model guide.

Record and Observations

SOAP field	Student record
S - subjective history	_____
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A - assessment / priorities	_____
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Monitoring / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

Viva Questions and Answers

1. What belongs in S?

The person's reported symptoms, concerns and relevant history.

2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

SOAP Case Study - Myocardial Infarction

Experiment 3 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional myocardial infarction case.

Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

Fictional Case and SOAP Guide

Section	Model teaching content
S - history	A fictional 58-year-old develops persistent chest pressure with sweating and nausea.
O - supplied findings	Supplied emergency-case ECG and troponin findings are marked abnormal by the instructor.
A - assessment	This is a simulated acute coronary emergency requiring immediate qualified assessment.
P - professional plan	Activate the emergency team; communicate onset and medicines/allergies; the team determines ECG, biomarker, reperfusion and medicine decisions.

Counselling and Monitoring

Counselling

After stabilisation, discuss the discharge plan, adherence, rehabilitation and risk reduction.

Monitoring

Team-defined haemodynamics, rhythm, symptoms, biomarkers and treatment safety.

Urgent Review

Persistent chest symptoms, haemodynamic instability or arrhythmia; do not delay transfer to finish a pharmacy worksheet.

Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

Practice Scenario

Original fictional case for discussion only.

Pharmacotherapeutics

Activity Procedure

1. Extract S and O

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

3. Prioritise

Check emergency/referral needs before routine counselling.

4. Plan

State the authorised review, counselling and monitoring steps.

5. Write

Complete the blank SOAP record and a concise handover using the model guide.

Record and Observations

SOAP field	Student record
S - subjective history	_____
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A - assessment / priorities	_____
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Monitoring / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

Viva Questions and Answers

1. What belongs in S?

The person's reported symptoms, concerns and relevant history.

2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

SOAP Case Study - Hyperlipidaemia

Experiment 4 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional hyperlipidaemia case.

Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

Fictional Case and SOAP Guide

Section	Model teaching content
S - history	A fictional 48-year-old has missed statin doses and asks whether the drug is necessary without symptoms.
O - supplied findings	Supplied lipid report: LDL cholesterol 165 mg/dL; other risk factors and previous cardiovascular history are incomplete.
A - assessment	Lipid risk cannot be assessed from one value alone; adherence and overall cardiovascular-risk information are needed.
P - professional plan	Review the prescription, interactions and risk context with the clinician; document a feasible adherence plan.

Counselling and Monitoring

Counselling

Explain preventive purpose, food/activity choices and reporting unexplained significant muscle symptoms.

Monitoring

Lipid follow-up and drug-specific safety assessment as prescribed.

Urgent Review

Severe muscle symptoms, dark urine or acute cardiovascular symptoms need prompt assessment.

Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

Practice Scenario

Original fictional case for discussion only.

Pharmacotherapeutics

Activity Procedure**1. Extract S and O**

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

3. Prioritise

Check emergency/referral needs before routine counselling.

4. Plan

State the authorised review, counselling and monitoring steps.

5. Write

Complete the blank SOAP record and a concise handover using the model guide.

Record and Observations

SOAP field	Student record
S - subjective history	_____
O - objective information	_____
A - assessment / priorities	_____
P - actions / review	_____
Monitoring / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

Viva Questions and Answers**1. What belongs in S?**

The person's reported symptoms, concerns and relevant history.

2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

SOAP Case Study - Rheumatoid Arthritis

Experiment 5 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional rheumatoid arthritis case.

Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

Fictional Case and SOAP Guide

Section	Model teaching content
S - history	A fictional 42-year-old has inflammatory joint disease and is uncertain about the weekly methotrexate day.
O - supplied findings	Supplied treatment record lists methotrexate, a prescribed folic-acid plan and scheduled blood monitoring.
A - assessment	A high-risk administration misunderstanding may coexist with inadequately controlled symptoms.
P - professional plan	Confirm weekly dose/day and tablet strength with the authorised record; arrange review of disease control and monitoring.

Counselling and Monitoring

Counselling

Use teach-back of the weekly schedule and distinguish DMARD purpose from short-term pain relief.

Monitoring

Blood counts, liver/renal tests and infection or other adverse-effect symptoms according to the prescribed plan.

Urgent Review

Any daily-versus-weekly dosing error, severe infection symptoms or concerning toxicity needs urgent advice.

Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

Pharmacotherapeutics

Practice Scenario

Original fictional case for discussion only.

Activity Procedure

1. Extract S and O

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

3. Prioritise

Check emergency/referral needs before routine counselling.

4. Plan

State the authorised review, counselling and monitoring steps.

5. Write

Complete the blank SOAP record and a concise handover using the model guide.

Record and Observations

SOAP field	Student record
S - subjective history	_____
O - objective information	_____
A - assessment / priorities	_____
P - actions / review	_____
Monitoring / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

Viva Questions and Answers

1. What belongs in S?

The person's reported symptoms, concerns and relevant history.

2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

SOAP Case Study - Asthma

Experiment 6 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional asthma case.

Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

Fictional Case and SOAP Guide

Section	Model teaching content
S - history	A fictional 19-year-old reports night symptoms and difficulty coordinating a metered-dose inhaler.
O - supplied findings	Supplied record shows repeated reliever use; technique and prescribed controller plan need review.
A - assessment	Poor technique and/or treatment adherence may contribute to poor control; acute distress must be screened.
P - professional plan	Review the exact inhaler regimen with the care team, correct technique and confirm an individual action plan.

Counselling and Monitoring

Counselling

Demonstrate the device, compatible spacer when indicated and product-specific after-use care.

Monitoring

Symptoms, night waking, reliever pattern, technique and prescribed lung-function follow-up.

Urgent Review

Severe breathing difficulty, inability to speak normally, exhaustion or poor response to the emergency plan.

Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

Practice Scenario

Original fictional case for discussion only.

Pharmacotherapeutics

Activity Procedure

1. Extract S and O

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

3. Prioritise

Check emergency/referral needs before routine counselling.

4. Plan

State the authorised review, counselling and monitoring steps.

5. Write

Complete the blank SOAP record and a concise handover using the model guide.

Record and Observations

SOAP field	Student record
S - subjective history	_____
O - objective information	_____
A - assessment / priorities	_____
P - actions / review	_____
Monitoring / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

Viva Questions and Answers

1. What belongs in S?

The person's reported symptoms, concerns and relevant history.

2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

SOAP Case Study - Chronic Obstructive Pulmonary Disease

Experiment 7 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional chronic obstructive pulmonary disease case.

Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

Fictional Case and SOAP Guide

Section	Model teaching content
S - history	A fictional 67-year-old has diagnosed COPD, continues smoking and describes worsening breathlessness.
O - supplied findings	Supplied spirometry report documents persistent airflow obstruction; current oxygen saturation and infection features need clinical assessment.
A - assessment	Assess whether this represents baseline limitation or an exacerbation; COPD diagnosis and severity use appropriate spirometric/clinical review.
P - professional plan	Arrange assessment of deterioration; review prescribed bronchodilator devices, cessation support and rehabilitation plan.

Counselling and Monitoring

Counselling

Demonstrate the exact inhaler and discuss avoiding smoke exposure and the prescribed preventive plan.

Monitoring

Symptoms, exacerbation history, device technique and clinician-directed oxygen/therapy monitoring.

Urgent Review

Severe breathlessness, cyanosis, confusion or acute deterioration.

Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

Pharmacotherapeutics

Practice Scenario

Original fictional case for discussion only.

Activity Procedure

1. Extract S and O

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

3. Prioritise

Check emergency/referral needs before routine counselling.

4. Plan

State the authorised review, counselling and monitoring steps.

5. Write

Complete the blank SOAP record and a concise handover using the model guide.

Record and Observations

SOAP field	Student record
S - subjective history	_____
O - objective information	_____
A - assessment / priorities	_____
P - actions / review	_____
Monitoring / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

Viva Questions and Answers

1. What belongs in S?

The person's reported symptoms, concerns and relevant history.

2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

SOAP Case Study - Diabetes Mellitus

Experiment 8 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional diabetes mellitus case.

Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

Fictional Case and SOAP Guide

Section	Model teaching content
S - history	A fictional adult with type 2 diabetes misses doses and reports thirst and frequent urination.
O - supplied findings	Supplied HbA1c 8.2%; renal function, current glucose and medication details require confirmation.
A - assessment	The teaching record suggests above-target glycaemic control; symptoms and adherence need timely review.
P - professional plan	Confirm the prescribed plan, assess for urgent illness and arrange clinical review of control and relevant complications.

Counselling and Monitoring

Counselling

Explain medicine routine, feasible food/activity changes, foot care and the individual low-glucose plan if relevant.

Monitoring

Clinician-set glucose/HbA1c goals and renal, eye and foot assessments.

Urgent Review

Vomiting, dehydration, altered consciousness, severe low-glucose symptoms or acute illness.

Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

Practice Scenario

Original fictional case for discussion only.

Pharmacotherapeutics

Activity Procedure**1. Extract S and O**

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

3. Prioritise

Check emergency/referral needs before routine counselling.

4. Plan

State the authorised review, counselling and monitoring steps.

5. Write

Complete the blank SOAP record and a concise handover using the model guide.

Record and Observations

SOAP field	Student record
S - subjective history	_____
O - objective information	_____
A - assessment / priorities	_____
P - actions / review	_____
Monitoring / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

Viva Questions and Answers**1. What belongs in S?**

The person's reported symptoms, concerns and relevant history.

2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

SOAP Case Study - Epilepsy

Experiment 9 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional epilepsy case.

Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

Fictional Case and SOAP Guide

Section	Model teaching content
S - history	A fictional 24-year-old with diagnosed epilepsy missed antiseizure doses and had a breakthrough event.
O - supplied findings	Supplied record lists an antiseizure medicine; exact seizure type, missed-dose advice and safety concerns need confirmation.
A - assessment	Review adherence and triggers without assuming the event needs a new drug; assess injury and recurrent/prolonged seizures.
P - professional plan	Arrange qualified review and reinforce the exact prescribed missed-dose and maintenance plan; do not abruptly stop therapy.

Counselling and Monitoring

Counselling

Discuss reminders, individual triggers, first aid and relevant activity/driving advice through the care team.

Monitoring

Seizure pattern, adherence, adverse effects and drug-specific monitoring.

Urgent Review

A seizure around 5 minutes, repeated events without recovery, breathing problems or significant injury.

Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

Practice Scenario

Original fictional case for discussion only.

Pharmacotherapeutics

Activity Procedure**1. Extract S and O**

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

3. Prioritise

Check emergency/referral needs before routine counselling.

4. Plan

State the authorised review, counselling and monitoring steps.

5. Write

Complete the blank SOAP record and a concise handover using the model guide.

Record and Observations

SOAP field	Student record
S - subjective history	_____
O - objective information	_____
A - assessment / priorities	_____
P - actions / review	_____
Monitoring / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

Viva Questions and Answers**1. What belongs in S?**

The person's reported symptoms, concerns and relevant history.

2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

SOAP Case Study - Stroke

Experiment 10 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional stroke case.

Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

Fictional Case and SOAP Guide

Section	Model teaching content
S - history	A fictional 70-year-old develops sudden facial droop, arm weakness and speech difficulty.
O - supplied findings	Family gives a last-known-well time of 10:00; current time is 10:30. Imaging and glucose assessment are not yet available.
A - assessment	The presentation is a simulated time-critical suspected stroke; bleeding versus ischaemia must be assessed clinically.
P - professional plan	Activate the emergency stroke pathway, report last-known-well and medicines; defer oral intake until swallowing is assessed and do not choose antithrombotics before the team assessment.

Counselling and Monitoring

Counselling

After stabilisation, discuss the authorised secondary-prevention and rehabilitation plan.

Monitoring

Team-directed neurological status, swallowing, functional recovery and medicine safety.

Urgent Review

Any new focal neurological deficit is an emergency even if it improves.

Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

Practice Scenario

Original fictional case for discussion only.

Pharmacotherapeutics

Activity Procedure**1. Extract S and O**

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

3. Prioritise

Check emergency/referral needs before routine counselling.

4. Plan

State the authorised review, counselling and monitoring steps.

5. Write

Complete the blank SOAP record and a concise handover using the model guide.

Record and Observations

SOAP field	Student record
S - subjective history	_____
O - objective information	_____
A - assessment / priorities	_____
P - actions / review	_____
Monitoring / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

Viva Questions and Answers**1. What belongs in S?**

The person's reported symptoms, concerns and relevant history.

2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

SOAP Case Study - Depression

Experiment 11 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional depression case.

Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

Fictional Case and SOAP Guide

Section	Model teaching content
S - history	A fictional 30-year-old reports low mood, loss of interest and disturbed sleep for several weeks.
O - supplied findings	The instructor provides a completed clinical assessment; current safety, supports and any medicine plan still need review.
A - assessment	Depressive symptoms require professional assessment and a direct, respectful safety check; other causes and bipolar history matter.
P - professional plan	Arrange mental-health review and assess immediate self-harm risk; imminent danger requires emergency help and supportive presence.

Counselling and Monitoring

Counselling

Explain the clinician's psychological/medicine plan, follow-up and reaching trusted support without stigma.

Monitoring

Symptoms, function, safety and any prescribed-treatment adverse effects.

Urgent Review

Immediate self-harm intent, inability to stay safe or other acute mental-health crisis.

Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

Practice Scenario

Original fictional case for discussion only.

Pharmacotherapeutics

Activity Procedure**1. Extract S and O**

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

3. Prioritise

Check emergency/referral needs before routine counselling.

4. Plan

State the authorised review, counselling and monitoring steps.

5. Write

Complete the blank SOAP record and a concise handover using the model guide.

Record and Observations

SOAP field	Student record
S - subjective history	_____
O - objective information	_____
A - assessment / priorities	_____
P - actions / review	_____
Monitoring / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

Viva Questions and Answers**1. What belongs in S?**

The person's reported symptoms, concerns and relevant history.

2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

SOAP Case Study - Tuberculosis

Experiment 12 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional tuberculosis case.

Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

Fictional Case and SOAP Guide

Section	Model teaching content
S - history	A fictional adult has a programme-confirmed TB diagnosis and asks about missed appointments.
O - supplied findings	The supplied case sheet documents treatment under the national TB service; regimen and monitoring are confirmed by the programme team.
A - assessment	Treatment interruption risks poor outcomes; identify barriers, adverse-effect concerns and service access.
P - professional plan	Reconnect the person with the TB team for the authorised treatment and monitoring plan; do not independently change medicines.

Counselling and Monitoring

Counselling

Discuss completing the prescribed programme, ventilation and respectful household advice from the service.

Monitoring

Programme-defined adherence, symptoms, weight and medicine-specific safety checks.

Urgent Review

Severe illness, breathing difficulty or serious suspected treatment toxicity.

Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

Practice Scenario

Original fictional case for discussion only.

Pharmacotherapeutics

Activity Procedure**1. Extract S and O**

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

3. Prioritise

Check emergency/referral needs before routine counselling.

4. Plan

State the authorised review, counselling and monitoring steps.

5. Write

Complete the blank SOAP record and a concise handover using the model guide.

Record and Observations

SOAP field	Student record
S - subjective history	_____
O - objective information	_____
A - assessment / priorities	_____
P - actions / review	_____
Monitoring / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

Viva Questions and Answers**1. What belongs in S?**

The person's reported symptoms, concerns and relevant history.

2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

SOAP Case Study - Iron-Deficiency Anaemia

Experiment 13 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional iron-deficiency anaemia case.

Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

Fictional Case and SOAP Guide

Section	Model teaching content
S - history	A fictional 32-year-old reports fatigue and heavy menstrual bleeding.
O - supplied findings	Supplied Hb 9.5 g/dL, MCV 74 fL and low ferritin are identified in the teaching report.
A - assessment	The pattern supports iron deficiency in the supplied case; the cause of blood loss and clinical severity require assessment.
P - professional plan	Arrange review of the underlying cause and the prescribed iron plan, tolerance and follow-up tests.

Counselling and Monitoring

Counselling

Explain the exact product instructions, interactions where relevant and keeping iron out of children's reach.

Monitoring

Haemoglobin/iron response and adverse effects at the prescribed follow-up.

Urgent Review

Chest pain, collapse, severe breathlessness or ongoing major bleeding.

Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

Practice Scenario

Original fictional case for discussion only.

Pharmacotherapeutics

Activity Procedure

1. Extract S and O

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

3. Prioritise

Check emergency/referral needs before routine counselling.

4. Plan

State the authorised review, counselling and monitoring steps.

5. Write

Complete the blank SOAP record and a concise handover using the model guide.

Record and Observations

SOAP field	Student record
S - subjective history	_____
O - objective information	_____
A - assessment / priorities	_____
P - actions / review	_____
Monitoring / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

Viva Questions and Answers

1. What belongs in S?

The person's reported symptoms, concerns and relevant history.

2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

SOAP Case Study - Viral Infection - Influenza

Experiment 14 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional viral infection - influenza case.

Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

Fictional Case and SOAP Guide

Section	Model teaching content
S - history	A fictional adult has fever, aches and cough for two days; risk factors and breathing symptoms must be assessed.
O - supplied findings	The instructor supplies a clinically assessed uncomplicated influenza case; current hydration and high-risk status are reviewed.
A - assessment	Viral illness does not automatically require an antibiotic; higher-risk or severe illness needs clinical review.
P - professional plan	Discuss suitable supportive measures and clinician assessment of antiviral eligibility where indicated; document safety-net advice.

Counselling and Monitoring

Counselling

Explain hydration, rest, respiratory hygiene and the individual preventive-vaccination review.

Monitoring

Symptoms, hydration, breathing and progression; high-risk patients need earlier review.

Urgent Review

Breathing difficulty, confusion, dehydration or marked deterioration.

Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

Practice Scenario

Original fictional case for discussion only.

Pharmacotherapeutics

Activity Procedure**1. Extract S and O**

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

3. Prioritise

Check emergency/referral needs before routine counselling.

4. Plan

State the authorised review, counselling and monitoring steps.

5. Write

Complete the blank SOAP record and a concise handover using the model guide.

Record and Observations

SOAP field	Student record
S - subjective history	_____
O - objective information	_____
A - assessment / priorities	_____
P - actions / review	_____
Monitoring / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

Viva Questions and Answers**1. What belongs in S?**

The person's reported symptoms, concerns and relevant history.

2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

SOAP Case Study - Dermatological Condition - Eczema

Experiment 15 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional dermatological condition - eczema case.

Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

Fictional Case and SOAP Guide

Section	Model teaching content
S - history	A fictional adult has an established eczema diagnosis and asks about applying the prescribed topical products.
O - supplied findings	Teaching photographs show a noninfected flare; product potency, site and directions need confirmation.
A - assessment	Review trigger exposure and correct use; distinguish a routine flare from infection or other concerning disease.
P - professional plan	Confirm the clinician's emollient and anti-inflammatory plan for the exact site and product; demonstrate suitable application.

Counselling and Monitoring

Counselling

Explain regular moisturising, gentle skin care and product-specific quantities/duration.

Monitoring

Skin response, correct use and signs of infection or adverse effects.

Urgent Review

Rapid spread, severe pain, fever, extensive blistering or eye-area concerns.

Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

Pharmacotherapeutics

Practice Scenario

Original fictional case for discussion only.

Activity Procedure

1. Extract S and O

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

3. Prioritise

Check emergency/referral needs before routine counselling.

4. Plan

State the authorised review, counselling and monitoring steps.

5. Write

Complete the blank SOAP record and a concise handover using the model guide.

Record and Observations

SOAP field	Student record
S - subjective history	_____
O - objective information	_____
A - assessment / priorities	_____
P - actions / review	_____
Monitoring / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

Viva Questions and Answers

1. What belongs in S?

The person's reported symptoms, concerns and relevant history.

2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

Clinical Patient Counselling - Primary Hypertension

Experiment 16 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To counsel a fictional person with primary hypertension.

Principle

Persistent blood-pressure elevation requires repeated assessment and a prescribed long-term plan.

Key Points

- Explain that symptoms may be absent.
- Review adherence, home-measurement technique and the prescribed follow-up.
- Discuss reduced excess salt, suitable activity and tobacco cessation in the person's context.

Practice Scenario

Fictional role-play case: A fictional adult stops tablets on days when the blood-pressure reading looks better.

Activity Procedure

1. Assess

Ask about understanding, actual medicine instructions, adherence and concerns.

2. Explain

Explain the medicine purpose and practical self-care in plain language.

3. Demonstrate

Demonstrate a relevant device or reminder method when applicable.

4. Plan

Explain regular prescribed use and arrange review instead of adjusting treatment from one reading.

5. Teach back

Ask the partner to repeat the plan and record follow-up needs.

Pharmacotherapeutics

Record and Observations

Topic	Counselling record
Medicine / adherence concern	_____
Key explanation	_____
Teach-back	_____
Referral / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Use the supplied case and medicine labels; do not issue a prescription.

Viva Questions and Answers**1. Why ask about actual use?**

Prescribed directions and the way a person uses treatment may differ.

2. Why use teach-back?

It checks practical understanding.

3. Can a student change the regimen?

No; treatment changes require the authorised clinician's plan.

Clinical Patient Counselling - Type 2 Diabetes

Experiment 17 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To counsel a fictional person with type 2 diabetes.

Principle

Long-term glucose management combines prescribed medicines, food/activity choices and complication monitoring.

Key Points

- Review the exact medicine plan and adherence barriers.
- Explain symptom recognition and the individual action plan for low glucose where relevant.
- Discuss foot care, eye/renal review and avoiding tobacco.

Practice Scenario

Fictional role-play case: A fictional adult misses evening medicine when travelling and has no routine follow-up record.

Activity Procedure

1. Assess

Ask about understanding, actual medicine instructions, adherence and concerns.

2. Explain

Explain the medicine purpose and practical self-care in plain language.

3. Demonstrate

Demonstrate a relevant device or reminder method when applicable.

4. Plan

Agree a medicine reminder, review the prescribed monitoring plan and refer symptoms or uncertainty to the care team.

5. Teach back

Ask the partner to repeat the plan and record follow-up needs.

Pharmacotherapeutics

Record and Observations

Topic	Counselling record
Medicine / adherence concern	_____
Key explanation	_____
Teach-back	_____
Referral / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Use the supplied case and medicine labels; do not issue a prescription.

Viva Questions and Answers**1. Why ask about actual use?**

Prescribed directions and the way a person uses treatment may differ.

2. Why use teach-back?

It checks practical understanding.

3. Can a student change the regimen?

No; treatment changes require the authorised clinician's plan.

Clinical Patient Counselling - Asthma

Experiment 18 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To counsel a fictional person with asthma.

Principle

Airway inflammation and variable narrowing make both correct inhaler use and an individual action plan important.

Key Points

- Check the actual reliever/controller plan; products and regimens differ.
- Demonstrate the exact inhaler and spacer when appropriate.
- Frequent symptoms or increasing reliever use need review; severe breathing difficulty needs urgent care.

Practice Scenario

Fictional role-play case: A fictional student uses an inhaler without coordination and has recurring night symptoms.

Activity Procedure

1. Assess

Ask about understanding, actual medicine instructions, adherence and concerns.

2. Explain

Explain the medicine purpose and practical self-care in plain language.

3. Demonstrate

Demonstrate a relevant device or reminder method when applicable.

4. Plan

Correct technique, confirm adherence and refer poor control to the care team.

5. Teach back

Ask the partner to repeat the plan and record follow-up needs.

Pharmacotherapeutics

Record and Observations

Topic	Counselling record
Medicine / adherence concern	_____
Key explanation	_____
Teach-back	_____
Referral / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Use the supplied case and medicine labels; do not issue a prescription.

Viva Questions and Answers**1. Why ask about actual use?**

Prescribed directions and the way a person uses treatment may differ.

2. Why use teach-back?

It checks practical understanding.

3. Can a student change the regimen?

No; treatment changes require the authorised clinician's plan.

Clinical Patient Counselling - Rheumatoid Arthritis

Experiment 19 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To counsel a fictional person with rheumatoid arthritis.

Principle

Disease-modifying treatment aims to control inflammation and limit joint damage; symptom relief alone has a different role.

Key Points

- Review the exact DMARD plan and required blood monitoring.
- For inflammatory-disease methotrexate, verify the once-weekly day and prescribed folic-acid plan.
- Report infection symptoms or concerning adverse effects to the care team.

Practice Scenario

Fictional role-play case: A fictional adult confuses the weekly methotrexate dose with daily medicines.

Activity Procedure

1. Assess

Ask about understanding, actual medicine instructions, adherence and concerns.

2. Explain

Explain the medicine purpose and practical self-care in plain language.

3. Demonstrate

Demonstrate a relevant device or reminder method when applicable.

4. Plan

Use teach-back of the weekly day and tablet count; any daily-use error needs urgent clinical advice.

5. Teach back

Ask the partner to repeat the plan and record follow-up needs.

Pharmacotherapeutics

Record and Observations

Topic	Counselling record
Medicine / adherence concern	_____
Key explanation	_____
Teach-back	_____
Referral / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Use the supplied case and medicine labels; do not issue a prescription.

Viva Questions and Answers**1. Why ask about actual use?**

Prescribed directions and the way a person uses treatment may differ.

2. Why use teach-back?

It checks practical understanding.

3. Can a student change the regimen?

No; treatment changes require the authorised clinician's plan.

Clinical Patient Counselling - Epilepsy

Experiment 20 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To counsel a fictional person with epilepsy about an existing treatment plan.

Principle

Adherence, an individual seizure-management plan and practical safety advice support ongoing epilepsy care.

Key Points

- Review exact prescribed directions and missed-dose advice.
- Do not stop antiseizure treatment abruptly without clinical direction.
- Discuss reminders, seizure first aid and agreed follow-up.

Practice Scenario

Fictional case: a student forgets evening doses when away from home. Agree a practical reminder and confirm the prescribed missed-dose guidance.

Activity Procedure

1. Assess

Ask about recent events, actual medicine use and barriers.

2. Explain

Review medicine purpose, prescribed routine and product-specific precautions.

3. Demonstrate

Role-play a reminder plan and how a supporter seeks help during a seizure.

4. Teach back

Ask for a repeat explanation of the plan and arrange care-team review.

Pharmacotherapeutics

Record and Observations

Concern / adherence	_____
Prescribed plan confirmed	_____
First aid / safety advice	_____
Teach-back / review	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Viva Questions and Answers**1. Why avoid abrupt withdrawal?**

It may worsen seizure control and needs an authorised plan.

2. Why involve a supporter with agreement?

They can assist with first aid and the agreed safety plan.

3. What should be recorded?

The confirmed directions, counselling, understanding and follow-up.

Paediatric Dose Calculation from a Given mg per kg per Dose Order

Experiment 21 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To verify a dose or supply calculation using an instructor-provided fictional prescription.

Principle

Dose (mg) = given mg/kg/dose × weight (kg); volume (mL) = ordered mg / concentration (mg/mL).

Fictional Given Order

A fictional prescriber order states 10 mg/kg per dose for a child weighing 18 kg; the teaching product is 120 mg/5 mL.

Requirements

- Given fictional prescription, body weight where relevant and product strength
- Calculator, unit-conversion worksheet and independent checker

Procedure

1. Read

Identify whether the order is per dose or per day and confirm all supplied units.

2. Calculate

Write the formula and substitute only the given values.

3. Convert

Convert mg to mL or tablet quantity using the actual product strength.

4. Check

Independently verify arithmetic, product suitability, dose limits and complete instructions through the authorised source.

5. Report

Record the calculated amount and any information still requiring clarification.

Pharmacotherapeutics**Observations and Record**

Field	Student calculation
Given order / weight	_____
Product strength / units	_____
Calculated mg per dose	_____
Calculated mL / tablets	_____
Independent check / clarification	_____

Worked Example

The numbers below are illustrative; enter your own observations in the record.

- Ordered dose = $10 \times 18 = 180$ mg per dose.
- Concentration = $120 / 5 = 24$ mg/mL.
- Volume = $180 / 24 = 7.5$ mL per dose.
- Frequency, maximum dose, indication and product suitability must be confirmed separately; this worksheet does not select them.

Result

Calculated amount: _____. Unit and independent checks: _____. Unresolved order/product information: _____.

Precautions

- These are arithmetic exercises with given orders, not recommended regimens.
- Rounding must follow the available measuring device and authorised policy.
- Do not infer a paediatric dose from an adult dose by an unvalidated rule.

Viva Questions and Answers**1. Why distinguish per day from per dose?**

Using one as the other can multiply or reduce the intended total.

2. Why verify the product strength?

The same medicine may have different concentrations or formulations.

3. Why use an independent check?

It helps detect arithmetic, unit and interpretation errors.

Paediatric Dose Calculation from a Given Daily Order

Experiment 22 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To verify a dose or supply calculation using an instructor-provided fictional prescription.

Principle

Calculate the total daily amount first, then divide by the prescribed number of doses.

Fictional Given Order

A fictional order states 30 mg/kg/day divided into three equal doses; weight 15 kg; teaching liquid 250 mg/5 mL.

Requirements

- Given fictional prescription, body weight where relevant and product strength
- Calculator, unit-conversion worksheet and independent checker

Procedure

1. Read

Identify whether the order is per dose or per day and confirm all supplied units.

2. Calculate

Write the formula and substitute only the given values.

3. Convert

Convert mg to mL or tablet quantity using the actual product strength.

4. Check

Independently verify arithmetic, product suitability, dose limits and complete instructions through the authorised source.

5. Report

Record the calculated amount and any information still requiring clarification.

Pharmacotherapeutics**Observations and Record**

Field	Student calculation
Given order / weight	_____
Product strength / units	_____
Calculated mg per dose	_____
Calculated mL / tablets	_____
Independent check / clarification	_____

Worked Example

The numbers below are illustrative; enter your own observations in the record.

- Daily dose = $30 \times 15 = 450$ mg/day.
- Each of three doses = $450 / 3 = 150$ mg.
- Concentration = $250 / 5 = 50$ mg/mL; each dose volume = 3.0 mL.
- Do not confuse mg/kg/day with mg/kg/dose.

Result

Calculated amount: _____. Unit and independent checks: _____. Unresolved order/product information: _____.

Precautions

- These are arithmetic exercises with given orders, not recommended regimens.
- Rounding must follow the available measuring device and authorised policy.
- Do not infer a paediatric dose from an adult dose by an unvalidated rule.

Viva Questions and Answers**1. Why distinguish per day from per dose?**

Using one as the other can multiply or reduce the intended total.

2. Why verify the product strength?

The same medicine may have different concentrations or formulations.

3. Why use an independent check?

It helps detect arithmetic, unit and interpretation errors.

Geriatric Dose Calculation from an Authorised Adjusted Order

Experiment 23 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To verify a dose or supply calculation using an instructor-provided fictional prescription.

Principle

Convert the already authorised adjusted dose into the available formulation, using consistent units.

Fictional Given Order

A fictional clinician has already adjusted an older adult's order to 125 mg per dose; teaching liquid strength is 250 mg/5 mL.

Requirements

- Given fictional prescription, body weight where relevant and product strength
- Calculator, unit-conversion worksheet and independent checker

Procedure

1. Read

Identify whether the order is per dose or per day and confirm all supplied units.

2. Calculate

Write the formula and substitute only the given values.

3. Convert

Convert mg to mL or tablet quantity using the actual product strength.

4. Check

Independently verify arithmetic, product suitability, dose limits and complete instructions through the authorised source.

5. Report

Record the calculated amount and any information still requiring clarification.

Observations and Record

Field	Student calculation
Given order / weight	_____
Product strength / units	_____
Calculated mg per dose	_____
Calculated mL / tablets	_____
Independent check / clarification	_____

Worked Example

The numbers below are illustrative; enter your own observations in the record.

- Concentration = 50 mg/mL.
- Required volume = $125 / 50 = 2.5$ mL per dose.
- The worksheet verifies volume; it does not decide the renal adjustment or dosing interval.
- Check the actual product, measuring device and authorised instructions.

Result

Calculated amount: _____. Unit and independent checks: _____. Unresolved order/product information: _____.

Precautions

- These are arithmetic exercises with given orders, not recommended regimens.
- Rounding must follow the available measuring device and authorised policy.
- Do not infer a paediatric dose from an adult dose by an unvalidated rule.

Viva Questions and Answers

1. Why distinguish per day from per dose?

Using one as the other can multiply or reduce the intended total.

2. Why verify the product strength?

The same medicine may have different concentrations or formulations.

3. Why use an independent check?

It helps detect arithmetic, unit and interpretation errors.

Geriatric Tablet Quantity and Supply Calculation

Experiment 24 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To verify a dose or supply calculation using an instructor-provided fictional prescription.

Principle

Dose fraction and treatment duration determine quantity; formulation suitability is a separate essential check.

Fictional Given Order

A fictional prescription states half of a specifically authorised divisible 10 mg tablet once daily for 28 days.

Requirements

- Given fictional prescription, body weight where relevant and product strength
- Calculator, unit-conversion worksheet and independent checker

Procedure

1. Read

Identify whether the order is per dose or per day and confirm all supplied units.

2. Calculate

Write the formula and substitute only the given values.

3. Convert

Convert mg to mL or tablet quantity using the actual product strength.

4. Check

Independently verify arithmetic, product suitability, dose limits and complete instructions through the authorised source.

5. Report

Record the calculated amount and any information still requiring clarification.

Pharmacotherapeutics**Observations and Record**

Field	Student calculation
Given order / weight	_____
Product strength / units	_____
Calculated mg per dose	_____
Calculated mL / tablets	_____
Independent check / clarification	_____

Worked Example

The numbers below are illustrative; enter your own observations in the record.

- Per-dose amount = $10 \times 0.5 = 5$ mg.
- Total amount over 28 days = $5 \times 28 = 140$ mg.
- Tablet quantity = $0.5 \times 28 = 14$ whole tablets.
- Verify the exact tablet is suitable for division; use the authorised alternative if division is not permitted.

Result

Calculated amount: _____. Unit and independent checks: _____. Unresolved order/product information: _____.

Precautions

- These are arithmetic exercises with given orders, not recommended regimens.
- Rounding must follow the available measuring device and authorised policy.
- Do not infer a paediatric dose from an adult dose by an unvalidated rule.

Viva Questions and Answers**1. Why distinguish per day from per dose?**

Using one as the other can multiply or reduce the intended total.

2. Why verify the product strength?

The same medicine may have different concentrations or formulations.

3. Why use an independent check?

It helps detect arithmetic, unit and interpretation errors.

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