

## CLINICAL ASSESSMENT – PHARMACY

Date of Assessment: \_\_\_\_\_ (dd/mm/yr)

Name of Assessor: \_\_\_\_\_

**Contact Information:**

Name of Pharmaceutical Premises: \_\_\_\_\_

Name of Managing Director/Owner: \_\_\_\_\_

Name of Superintendent Pharmacist: \_\_\_\_\_

Registration: \_\_\_\_\_  
(*Pharmaceutical Premises*)

Address: \_\_\_\_\_ Ward: \_\_\_\_\_

City: \_\_\_\_\_ LGA: \_\_\_\_\_ State: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Personnel:**

Q1. How many staff do you have and their qualifications, including yourself?

Pharmacists \_\_\_\_\_

Nurses \_\_\_\_\_

Nurse/Midwives \_\_\_\_\_

CHEWS: \_\_\_\_\_

Pharmacy Attendants \_\_\_\_\_

Pharmacy Technicians \_\_\_\_\_

Others: \_\_\_\_\_

Q2. Trainings /CMEs attended with dates (related to FP/RH)

S/NO	Training Topic	Organizer	Dates

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**Service Provision:**

Q3. What contraceptive services do you provide?

Type	Yes/No	Type by Brand	Quantity of Sales/ week
Counseling			
Condoms			
Oral Contraceptive Pills			
Emergency Contraceptive Pills			
Injectables			
IUCD			
Implants			
Others			

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Q4. How many people do you sell contraceptive supplies to on a daily basis, on average?  
(Number) \_\_\_\_\_

Q5. How would you handle a Client who requests for a service you do not offer?

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Q6. If you do not offer FP services requested for do you refer? \_\_\_\_\_

Q7. If yes to Q5 above: Where? \_\_\_\_\_

Q8. What is your main source of contraceptive supplies? \_\_\_\_\_

Q9. What will make you not provide a method for a client?

**Records:**

Q10. What record keeping method do you use?

\_\_\_\_\_

\_\_\_\_\_

Daily sales book  Receipts/invoices  None  Computer  Other (for interviewer use)

**Infrastructure/ Premises**

Q11. Clean and tidy?  Yes  No

Q12. Are there FP Posters on display?  Yes  No If yes, describe:

\_\_\_\_\_

Q13. Private Counseling area?  Yes  No

Does it ensure privacy? (Visual, Yes/ No), (Auditory Yes/No) Circle as appropriate

**Other:**

Q14. Are you willing to join the Family Planning Providers Network?

Yes  No

If No Why? \_\_\_\_\_