

# Protocol for Management of Acute Mild Musculoskeletal Pain

The Victorian Community Pharmacist Program

May 2026

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Department  
of Health

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# 1. About

This Protocol has been developed to provide pharmacists authorised under the Drugs, Poisons and Controlled Substances Regulations 2017 (the Regulations) a clear framework to supply the Schedule 4 poisons documented in this Protocol for the purpose of managing acute, mild musculoskeletal pain under a structured prescribing arrangement. It is a requirement of the Secretary Approval: Community Pharmacist Program that pharmacists comply with this Protocol when supplying Schedule 4 poisons for patients seeking treatment for acute, mild musculoskeletal pain. It is also a requirement of the Secretary Approval: Community Pharmacist Program that pharmacists have completed the designated pharmacist training course before supplying Schedule 4 poisons.

Pharmacists authorised to supply Schedule 4 poisons under the Regulations must:

- Operate at all times in accordance with the Drugs, Poisons and Controlled Substances Act 1981, the Regulations and all other applicable Victorian, Commonwealth and national laws.
- At all times act in a manner consistent with the Pharmacy Board of Australia's (the Board) Code of Conduct and in keeping with other professional guidelines and policies as set out by the Board as applicable.

Pharmacists are expected to exercise professional judgment in adapting treatment guidelines to presenting circumstances.

## 1.1. Definitions and acronyms

**Acute musculoskeletal pain:** sudden pain affecting muscles, bones, joints, ligaments, or tendons, typically lasting less than three months and often resolving as the underlying injury heals. It arises from damage or structural changes, often due to trauma, falls, or overuse, and can feel sharp, throbbing, or cause stiffness and muscle ache. Examples include sprained ankles, bone fractures, or muscle strains.

**ARF:** Acute rheumatic fever

**COX-1:** Cyclo-oxygenase 1

**COX-2:** Cyclo-oxygenase 2

**CV:** Cardiovascular

**DVT:** Deep vein thrombosis

**eGFR:** Estimated glomerular filtration rate

**GI:** Gastrointestinal

**MHR:** My Health Record

**MSK:** Musculoskeletal

**NSAIDs:** Non-steroidal anti-inflammatory drugs

**Range of motion:** the full degree of movement possible at a joint, including the distance and direction a joint can move without causing pain

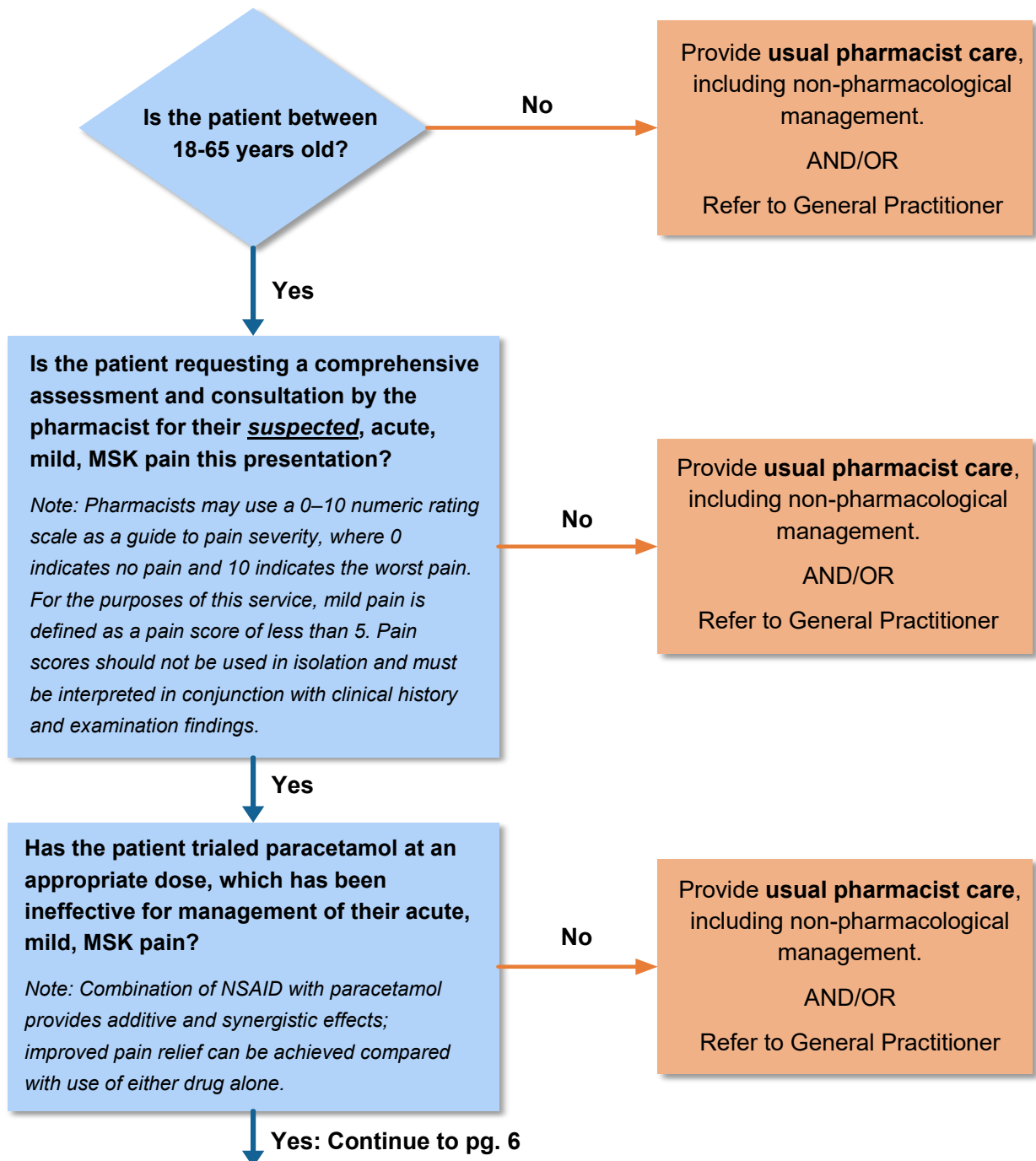
**SSRIs:** Selective serotonin reuptake inhibitors

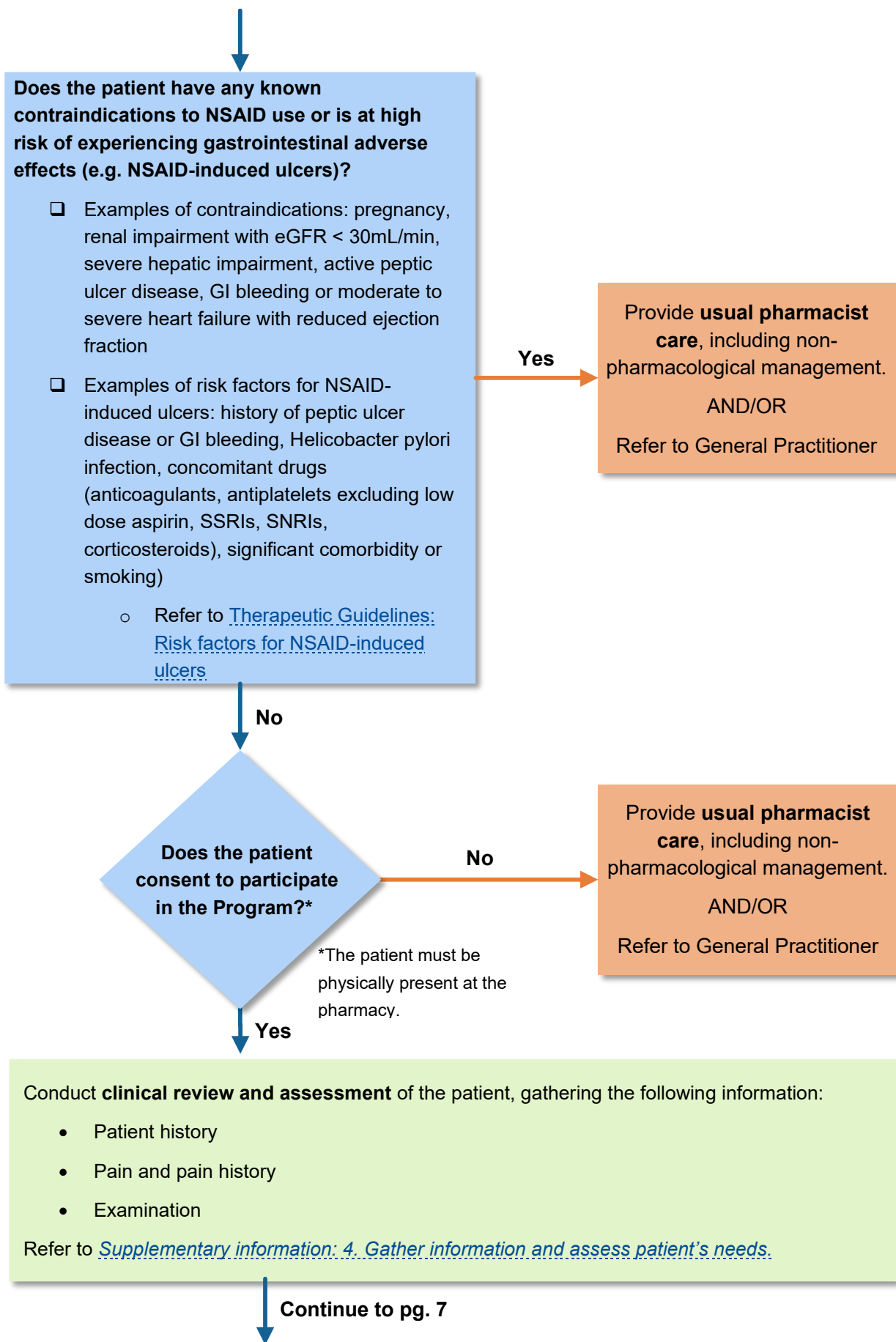
**SNRIs:** Selective noradrenaline reuptake inhibitors

## 2. Protocol for the Management of Acute, Mild Musculoskeletal Pain

### 2.1. Key to colours used in this protocol

Where the protocol indicates to “Refer to General Practitioner”, the Pharmacist may refer to a medical practitioner or other authorised prescribing health practitioner as clinically appropriate. If timely access to a GP is not available, referral to the [Victorian Virtual Emergency Department \(VVED\)](#) or an [urgent care clinic](#) may be considered as an alternative pathway.





Continued from pg. 6

Does the patient have any **'red flag'** warning signs?

- Acute swelling, erythema and significant reduction in range of motion of a joint
- Headache and/or acute onset of visual or auditory disturbances, or symptoms suggestive of known or suspected concussion
- Signs of vascular compromise (e.g. cold, pale, numb or painful extremity)
- Suspected nerve damage or mononeuropathy (e.g. loss of feeling, weakness, 'pins and needles', burning pain and/or paresthesia)
- Neurological signs (e.g. altered bowel or bladder function)
- Systemic signs and/or symptoms suggestive of serious pathology including weight loss, nausea and vomiting, fever, malaise, tachycardia, hypotension
- Recent intravenous drug use
- Risk of fracture (e.g. osteoporosis (and associated therapies including bisphosphonates or denosumab), significant trauma or history of cancer)
- Unilateral calf tenderness with no history of recent trauma or risk factors for DVT
- Pitting oedema
- New onset limb deformity
- New onset of skin rash
- Severe or high-risk mechanism of injury (e.g. cyclist/motorcyclist impact >30 km/hr, high-speed traffic incident, pedestrian impact, fall or falling object >3 m)

Yes

Refer to a medical practitioner **immediately**

No to all: Continue to pg. 8

↓ Continued from pg. 7

Does the patient meet these **exclusion criteria** warranting referral?

- Pain cannot be attributed to acute, mechanical MSK trauma or injury (e.g. has characteristics of chronic pain) - refer to Table 1.1
- Chest pain (including chest wall pain) where a serious non-musculoskeletal cause cannot be confidently excluded, or where symptoms are atypical, exertional, radiating, associated with systemic features, or occur in patients with significant cardiovascular risk.
- History of chronic inflammatory pain or underlying rheumatological conditions (including an acute flare of these conditions)
- Presents with swelling, redness, tenderness and warmth around a joint or within a muscle or other signs indicating serious pathology
- At high risk of acute rheumatic fever (refer to: [Therapeutic Guidelines: Acute rheumatic fever](#))
- Patient rates pain as moderate to severe
- Significant functional limitations due to pain
- Patient is intoxicated due to drugs and/or alcohol
- Patient is unable to accurately describe pain due to cognitive impairment or other special needs
- Inadequate response to optimal treatment or pain/other symptoms worsens within 5 days
- Requesting treatment with an opioid or other therapies not in scope of this practice
- Patient is opioid-tolerant or recovering from an opioid use disorder
- Presenting with traumatic injuries that may require radiological examination
- History of NSAID-exacerbated respiratory disease/asthma sensitivity, or previous bronchospasm/wheeze/acute asthma symptoms after aspirin or any NSAID.

Yes

Refer to General Practitioner  
**AND**  
Consider engaging the patient with a physiotherapist or osteopath

No, to all

Patient is confirmed to have acute, mild, MSK pain this presentation?

No

Provide **usual pharmacist care**, including non-pharmacological management.  
**AND/OR**  
Refer to General Practitioner  
**AND/OR**  
Consider engaging the patient with a physiotherapist or osteopath if indicated

Yes: Continue to pg. 9

Continued from pg. 8

Is the patient requesting a medication that they have used before from [Medicines List: The Program](#) for the treatment of a prior episode of acute, mild, MSK pain that has been effective?

Yes

Provide the medication as outlined by the [Medicines List: The Program](#) if appropriate

No

Provide **one** NSAID listed under the **Medicines** section of the protocol.

The choice of NSAID depends on the patient's:

- Past medical history, allergies and precautions
- Risk of CV events: Pharmacists may use the [AusCVD risk calculator](#) where cardiovascular risk status is uncertain.

*Patients at high risk of experiencing gastrointestinal adverse effects are excluded from this service and should not receive NSAIDs under this protocol.*

Patient is **not** at high CV event risk

Patient **is** at high CV event risk

**Choose any NSAID**

Refer to [Medicines](#) section of the protocol for options

**Preferred NSAIDs**

Celecoxib 200mg, oral, daily or less

OR

Naproxen 500mg, oral, twice daily or less

OR

Ibuprofen at doses of 1200mg, oral, daily (in 3-4 divided doses) or less

AND

AVOID DICLOFENAC and MELOXICAM

Provide non-pharmacological and self-care advice:

- Refer to the [Therapeutic Guidelines: Principles of nonpharmacological management for acute soft-tissue limb conditions](#) for strategies to help with acute, subacute and nonacute stage of injury: to help with acute, subacute and nonacute stage of injury.
- Reduced activity (which may include immobilisation) for no longer than 24 hours
- Encourage **PRICE** (protection, rest, ice, compression and elevation) for up to 24 hours of [soft-tissue limb conditions](#)
- Practice optimal loading beyond 24-48 hours of injury
- Avoid heat, alcohol, massage and vigorous exercise within first 48 hours of [soft-tissue limb conditions](#)
- Ensure rehabilitation in the nonacute stage of injury to improve recovery

Yes: Continue to pg. 10

Continue to pg. 10

Continued from pg. 9

Confirm management plan is appropriate with regards to contraindications, precautions, interactions and lactation status.

Communicate agreed treatment plan to patient and other healthcare professionals:

- Dispense medications via pharmacy dispensing program
- Counselling for the NSAID given (e.g., dose, duration, potential side effects)
- Duration of treatment and expectations around resolution of symptoms
- Consider engaging with or referral to a physiotherapist or osteopath
- Advise when to seek further care e.g. pain relief provided is not adequate, symptoms do not start to improve within 5 days, or if pain or other symptoms worsen

Document the consultation and share a record of the service with the patient, patient's usual treating GP or medical practice where the patient has one

### 3. Clinical Documentation Requirements

The pharmacist must make a clinical record of the consultation that contains:

- Sufficient information to identify the patient (Medicare number and date of birth are usually recorded when dispensing prescriptions)
- Date of treatment
- Name of the pharmacist who undertook the consultation and their Healthcare Provider Identifier-Individual (HPI-I) number
- Consent given by the patient regarding: Program participation, costs, pharmacist communication with other healthcare practitioners (e.g. patient's usual treating GP) and access to the patient's MHR for the purpose of checking inclusion/exclusion criteria and uploading information relating to the consultation as required
- Any information known to the pharmacist that is relevant to the patient's diagnosis or treatment and any observations and assessments including allergies and adverse reactions
- Any clinical opinion reached by the pharmacist
- Actions taken by the pharmacist, including management plan and/or referrals made to a medical practitioner or other healthcare professionals
- The particulars of any medications supplied to the patient, such as formulation, strength and amount
- Information or advice given to the patient in relation to any treatment proposed by the pharmacist such as counselling on side effects

The pharmacist must share a copy of the record of the service with the patient and with the patient's usual treating medical practitioner or medical practice, where the patient has one.

The pharmacist must make a record in the pharmacy software and an IT system approved by the Victorian Department of Health, regarding the supply.

## Supplementary information

The supplementary information provided below has been included to assist Victorian pharmacists participating in the Community Pharmacist Program (the Program). It is intended to be used together with the guidelines and other resources referred to here to assist pharmacists in adhering to the management protocol and facilitate delivery of a safe and high-quality service to the community for management of acute, mild musculoskeletal pain.

## 4. Gather information and assess patient's needs

### 4.1. Patient history

Sufficient information must be obtained from the patient to assess the safety and appropriateness of any recommendations and medicines for the patient.

Consider:

- Age
- Pregnancy and lactation status, including patients planning pregnancy (if applicable)
- Co-existing or underlying medical conditions, including rheumatological and autoimmune conditions (e.g. inflammatory arthritis and psoriasis), cancer, osteoporosis, immunosuppression, gastrointestinal, cardiovascular, and renal disease
- Family history of inflammatory pain, rheumatological and/or autoimmune conditions
- Surgical history, including any recent spinal, joint or dental procedures, and the presence of any prosthetic joints or implants
- Cardiovascular risk assessment, including history of established cardiovascular disease and, where appropriate, estimation of absolute cardiovascular risk using the [AusCVD risk calculator](#)
- Risk factors for developing ARF as per the [Therapeutic Guidelines: Acute rheumatic fever](#)
- Onset, duration, nature, location, severity of musculoskeletal pain and mechanism of injury if applicable, radiation and associated symptoms
- Other signs and symptoms that may indicate serious pathology, including weight-loss or gain, new rash, joint pain and/or hot swollen joints, fever, malaise, nausea, vomiting and sweating
- Weight, dietary patterns, level of exercise and/or physical activity
- Precipitating, aggravating and relieving/alleviating factors (including medications, therapy trialed for this episode of pain or if patient has seen a physiotherapist or osteotherapist for current episode of pain)
- Response to pharmacotherapy for previous episodes of acute, mild, MSK pain
- Impacts to quality of life including sleep, ability to self-care, mobility, work, leisure, emotional health and relationships and other psychosocial factors
- Current, recently commenced or recently ceased medications (including prescribed medicines, vitamins, herbs, other supplements and over-the-counter medicines)
- Drug allergies/adverse drug effects including NSAID-exacerbated asthma
  - Poorly controlled or recently unstable asthma (e.g. recent exacerbation requiring urgent medical review or oral corticosteroids), or current clinically significant asthma symptoms
- Alcohol, tobacco and other drug history/status
  - Consider recency of last intravenous drug use
- If the mechanism of injury, including speed, height of fall, and forces involved.
  - High-risk mechanisms of injury are not compatible with acute, mild MSK pain and require referral for medical assessment, even if initial pain appears mild.
- If the injury/onset of acute pain occurred in a workplace
- If the patient has been, suspected to have been, subject to non-accidental injury (e.g. domestic abuse, self-harm)

- Other psychosocial factors (e.g. mood, memories, cognition, psychiatric disorders, personality factors)

The patient's MHR can be used to access a range of clinical information including details about current and past medication history, allergies and current medical conditions.

## 4.2. Pain and pain history assessment

Acute MSK pain is primarily nociceptive and mechanical in nature, caused by damage to tissue or structural changes to joints, vertebrae and muscles or soft tissue. Injury is the most common cause of acute, mechanical MSK pain and is expected to be self-limiting (lasting less than 3 months), with a return to usual function as the underlying injury resolves.

Pain and history assessment should be conducted in accordance with the [Therapeutic Guidelines: General principles of acute pain management](#) and [Therapeutic Guidelines: Assessing a patient with pain](#). Pain severity is subjective and should be interpreted in context of the patient's presentation as well as additional information obtained through the history. If the patient's reported pain severity does not align with other objective assessments (e.g. physical function or examination findings), refer the patient to a healthcare provider for a thorough evaluation that includes consideration of socio-psycho-biomedical factors. Refer to [Therapeutic Guidelines: Understanding pain](#).

## 4.3. Examination

The area(s) of pain should be examined in accordance with the [Therapeutic Guidelines: Overview of the clinical assessment of musculoskeletal symptoms in adults](#) and if applicable, [Therapeutic Guidelines: Assessment of back and neck pain](#) and/or [Therapeutic Guidelines: Overview of limb conditions](#).

To guide proper management or referral, it is crucial to identify the underlying cause of the pain and differentiate between pain related to inflammation from a chronic condition compared to mechanical pain. See Table 1.1.

**Table 1.1 Clinical features/characteristics of inflammatory versus mechanical pain**

INFLAMMATORY PAIN	MECHANICAL (musculoskeletal) PAIN
<ul style="list-style-type: none"> <li>• Improves with exercise/movement</li> <li>• Does not improve with rest</li> <li>• Lasts more than 3 months</li> <li>• Morning stiffness (for greater than 30 minutes)</li> <li>• Pain waking patient during second half of the night, with improvement when getting up</li> </ul>	<ul style="list-style-type: none"> <li>• May worsen with exercise/movement</li> <li>• Often improves with rest</li> <li>• Acute onset, lasting less than 3 months</li> <li>• Precipitating physical injury may be identifiable</li> </ul>

When appropriate, assess signs and symptoms to identify '**red flags**' and/or exclusion criteria.

Patients who have any '**red flag**' or exclusion criteria are not eligible for this service and must be referred *immediately* to their regular medical practitioner, health service or the Emergency Department if requiring urgent care.

**'Red flag'** warning signs requiring **immediate referral** to a medical practitioner:

- Acute swelling, erythema and significant reduction in range of motion of a joint
- Headache and/or acute onset of visual or auditory disturbances, or symptoms suggestive of known or suspected concussion
- Vascular compromise (e.g. cold, pale, numb or painful extremity)
- Suspected nerve damage or mononeuropathy (e.g. loss of feeling, weakness, 'pins and needles', burning pain and/or paresthesia)
- Neurological signs (e.g. altered bowel or bladder function)
- Systemic signs and/or symptoms suggestive of serious pathology including weight loss, nausea and vomiting, fever, malaise, tachycardia, hypotension
- Recent intravenous drug use
- Risk of fracture (e.g. osteoporosis (and associated therapies including bisphosphonates or denosumab), significant trauma or history of cancer)
- Unilateral calf tenderness with no history of recent trauma or risk factors for DVT
- Pitting oedema
- New onset limb deformity
- New onset of skin rash
- Severe or high-risk mechanism of injury (e.g. cyclist/motorcyclist impact >30 km/hr, high-speed traffic incident, pedestrian impact, fall or falling object >3 m)

**Exclusion criteria warranting referral:**

- Pain cannot be attributed to acute, mechanical MSK trauma or injury (e.g. has characteristics of chronic pain) - refer to Table 1.1
- Chest pain (including chest wall pain) where a serious non-musculoskeletal cause cannot be confidently excluded, or where symptoms are atypical, exertional, radiating, associated with systemic features, or occur in patients with significant cardiovascular risk
- History of chronic inflammatory pain or underlying rheumatological conditions (including an acute flare of these conditions)
- Presents with swelling, redness, tenderness and warmth around a joint or within a muscle or other signs indicating serious pathology
- At high risk of acute rheumatic fever (refer to: [Therapeutic Guidelines: Acute rheumatic fever](#))
- Patient rates pain as moderate to severe
- Significant functional limitations due to pain
- Patient is intoxicated due to drugs and/or alcohol
- Patient is unable to accurately describe pain due to cognitive impairment or other special needs
- Inadequate response to optimal treatment or pain/other symptoms worsens within 5 days
- Requesting treatment with an opioid or other therapies not in scope of this practice
- Patient is opioid-tolerant or recovering from an opioid use disorder
- Presenting with traumatic injuries that may require radiological examination
- History of NSAID-exacerbated respiratory disease/aspirin sensitivity, or previous bronchospasm/wheeze/acute asthma symptoms after aspirin or any NSAID

## 5. Management and treatment plan

Pharmacist management of acute, mild MSK pain involves:

1. **Non-pharmacological management strategies and lifestyle measures** in accordance with the [Therapeutic Guidelines: Non-pharmacological management of acute pain](#)
  - Pharmacists should provide advice on both non-pharmacological and pharmacological strategies in accordance with the Therapeutic Guidelines or management of acute, mild MSK pain at specific anatomical sites (e.g. limb conditions, nonspecific low back pain, neck pain or thoracic spine pain).
  - Consider engaging with or referring the patient to a physiotherapist or osteopath to assist with recovery and management.
2. **Pharmacotherapy** in accordance with [Therapeutic Guidelines: Pharmacological management of acute pain](#)
  - The recommended first-line pharmacotherapy treatment is regular oral paracetamol. Patients can also trial topical NSAIDs (minimal systemic absorption compared to oral NSAIDs) if paracetamol is inadequate.
  - If oral NSAID therapy is required, use the lowest effective dose of NSAID for the shortest amount of time possible. There is no rationale for using more than one NSAID at a time (excluding low-dose aspirin).
  - Combine NSAID with paracetamol for synergistic effects as improved pain relief can be achieved when using the combination compared to using either drug alone.

### 5.1. Confirm management is appropriate

Pharmacists must consult the Therapeutic Guidelines, Australian Medicines Handbook and other relevant references to confirm the treatment recommendation is appropriate, including for:

- Contraindications and precautions
- Drug interactions
- Lactation status

## 6. Medicines

According to [Therapeutic Guidelines: Principles of NSAID use for musculoskeletal pain](#), all NSAIDs are first-line, except for diclofenac, which is second-line due to its higher risk of contributing to CV events. There is little difference in anti-inflammatory efficacy between NSAIDs - choice should be based on individual response and tolerance, patient factors (including precautions, past medical history) and a balance of the risk and benefits. Opioids and neuropathic agents are not indicated for the management of most acute, mild MSK pain and cannot be provided as part of this Program.

Where a patient has elected for 'a *comprehensive assessment and consultation by the pharmacist*' and **confirmed** to be experiencing a current episode of acute, mild, MSK pain, the pharmacist may provide any medication from [Medicines List: Usual Pharmacist Care](#) or [Medicines List: The Program](#) as clinically appropriate.

### Medicines List: Usual Pharmacist Care

Generic name	Strength	Preparation	Dose
<b>Non-selective NSAIDs (COX-1 and COX-2 inhibitors)</b>			
Ibuprofen	200mg, 400mg	Tablet	200mg-400mg, oral, THREE to FOUR times daily
Diclofenac	12.5mg, 25mg	Tablet or Capsule	25mg-50mg, oral, TWO to THREE times daily
<b>Selective NSAIDs (COX-2 inhibitors)</b>			
Celecoxib	200mg	Capsule	200mg, oral, ONCE or TWICE daily

*Note: These medications can also be provided by the pharmacist outside of the Program or when 'usual pharmacist care' has been identified as appropriate for the patient in accordance with their relevant Schedule 2 or Schedule 3 requirements.*

### Medicines List: The Program

The Program authorises that pharmacists can supply a **maximum quantity sufficient for 5 days** duration of the medicines listed below for the treatment of acute, mild MSK pain.

Generic name	Strength	Preparation	Dose
<b>Non-selective NSAIDs (COX-1 and COX-2 inhibitors)</b>			
Diclofenac	25mg, 50mg	Immediate- release tablet	25mg-50mg, oral, TWO to THREE times daily
Naproxen	250mg, 500mg	Immediate- release tablet	250mg-500mg, oral, TWICE daily
	750mg, 1000mg	Extended- release tablet	750mg-1000mg, oral, ONCE daily
Naproxen sodium	550mg (equivalent to 500mg naproxen)	Immediate- release tablet	550mg, oral, STAT then 275mg, oral, every 6 to 8 hours <i>(maximum dose of 1375mg per 24 hours)</i>

*Table continued pg 18.*

**Medicines List: The Program** (continued)

<b>Generic name</b>	<b>Strength</b>	<b>Preparation</b>	<b>Dose</b>
<b>Selective NSAIDs (COX-2 inhibitors)</b>			
Celecoxib	100mg, 200mg	Capsule	100mg-200mg, oral, ONCE or TWICE daily
Meloxicam	7.5mg, 15mg	Tablet or Capsule	7.5mg-15mg, oral, ONCE daily

## 7. Communicate agreed management plan

Comprehensive advice and counselling (including supporting written information when required) as per the Therapeutic Guidelines, Australian Medicines Handbook and other relevant references should be provided to the patient regarding:

- Management options and expectations for resolution
- Product and medication use including dosing, treatment regimens, application instructions (where indicated) and duration
- How to manage adverse effects of treatment
- Non-pharmacological, general and preventative measures
- When to seek further care and/or treatment, including recognising red flag symptoms

It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources and information provided to patients, and to ensure compliance with all copyright conditions.

The agreed management plan should be shared with the patient's multidisciplinary healthcare team and MHR, with the patient's consent.

### 7.1. General advice

General advice should be provided to the patient regarding strategies to manage acute, mild MSK pain.

- Physical interventions may provide adequate pain relief on their own (e.g. heat therapy)
- Refer to the [Therapeutic Guidelines: Principles of nonpharmacological management for acute soft-tissue limb conditions](#) for strategies to help with acute, subacute and nonacute stage of injury: to help with acute, subacute and nonacute stage of injury:
- Reduced activity (which may include immobilisation) for no longer than 24 hours
- Encourage **PRICE** (protection, rest, ice, compression and elevation) for up to 24 hours of [soft-tissue limb conditions](#)
- Practice optimal loading beyond 24-48 hours of injury
- Avoid heat, alcohol, massage and vigorous exercise within first 48 hours of [soft-tissue limb conditions](#)
- Ensure rehabilitation in the nonacute stage of injury to improve recovery
- Pharmacists should support patients who are using complementary or non-evidence-based therapies by explaining the current evidence, potential harms, and interactions with conventional medicines, and guiding evidence-based care.

Patients should be advised to see a medical practitioner if:

- Pain relief provided is not adequate; or
- Symptoms do not start to improve within 5 days; or
- Pain or other symptoms worsen; or
- Experience new pain or symptoms

## 8. Follow up / clinical review

If follow up and clinical review is required and/or the condition does not improve or resolve, the patient should be advised to see a medical practitioner for further investigation.

## 9. Resources

### 9.1. Resources for Pharmacists

#### [Therapeutic Guidelines](#)

- Rheumatology
- Pain and analgesia

#### [Australian Medicines Handbook](#)

- Drugs for pain relief
- Non-steroidal anti-inflammatory drugs

Physiopedia: [Peace and Love Principle](#)

Australian and New Zealand College of Anaesthetists and Faculty of Pain – Acute Pain Management: [Scientific Evidence](#)

Australian Prescriber: [Choosing a nonsteroidal anti-inflammatory drug for pain](#)

Rheumatic Heart Disease Australia: [ARF RHD Guideline and risk calculator](#)

Professional Practice Standards: [Professional Practice Standards – Version 6](#)

### 9.2. Patient information

Better Health Channel

- [Pain and pain management - adults](#)
- [Bones, muscles and joints](#)
- [Medications – non-steroidal anti-inflammatory drugs](#)

Health Direct

- [Sprains and strains](#)
- [Back pain](#)
- [Lower back pain](#)
- [Upper back pain \(thoracic pain\)](#)
- [Neck pain](#)
- [Anti-inflammatory medicines \(NSAIDs\)](#)