Medicine Review Form

Patient Name/ Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Completing Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did the patient say they brought in all of their prescription medicine containers?

Yes, patient said they brought in all of their prescription medicine containers.

No, patient said they brought in some of their prescription medicine containers, but not all of them.

No, patient did not bring in any of their prescription medicines and supplements (skip to #3).

The patient does not have any prescription medicines (skip to #4).

I did not check whether the patient brought in all their prescription medicine containers.

1. How many prescription medicines did the patient bring in? \_\_\_\_\_\_\_\_
2. How many prescription medicines did you review with the patient? \_\_\_\_\_\_\_\_
3. Did the patient say they brought in all of their over-the-counter medicines and supplements?

Yes, patient said they brought in all of their over-the-counter medicines and supplements.

No, patient said they brought in some of their over-the-counter medicines and supplements, but not all of them.

No, patient did not bring in any of their over-the-counter medicines and supplements. (Skip to #6)

The patient does not have any over-the-counter medicines or supplements. (Skip to #6)

I did not check whether the patient brought all over-the-counter medicines and supplements.

1. How many over-the-counter medicines and supplements did the patient bring in? \_\_\_\_\_\_\_\_
2. How many over-the-counter medicines and supplements did you review with the patient? \_\_\_\_\_\_\_\_
3. Was the patient able to show you correctly how and when they took each of the medicines you reviewed with the patient?

Yes.

No, patient was unable to show me correctly how and when they took at least one medicine.

I did not ask.

1. What problems were found with the medicine regimen? Please mark all that apply.

Duplicate medicines.

Expired medicines.

Patient had contraindications for one or more medicines.

Possible drug-drug interaction.

Patient is taking medicine incorrectly (e.g., wrong dose, wrong frequency).

Patient is not taking any of a medicine that is in the medical record (e.g., failed to refill, too expensive, side effects, didn’t know was supposed to take).

Patient is taking a prescription medicine not in the medical record (e.g., prescribed by another doctor, prescription samples).

Patient is taking an over-the-counter medicine or supplement that is not in the medical record.

Other – Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No problems. Thank you for completing this form. You are now done.

1. Did any of these problems represent a possible risk to patient safety?

Yes.

Possibly.

No.

1. Would any of these problems explain negative symptoms the patient has been experiencing?

Yes.

Possibly.

No.

Patient was not experiencing negative symptoms.

1. Were changes were made to the medicine regimen? Please mark all that apply.

Yes, the medicine regimen was simplified (e.g., fewer doses per day).

Yes, the total number of medicines was reduced**.**

Yes, other – Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No changes were made.