PRINT

PEI PharmaCheck™

1. MY MEDICATION CHECK-UP

PATIENT TO COMPLETE THIS PAGE

Name

Address

Postal code Phone

Health Insurer

Family Doctor

Phone FAX

Eligible for government coverage? ◯Yes ◯No

Who helps with your medication?

Pharmacist

✓ Declaration of consent: I agree to have a basic medication review performed by my pharmacist and to allow my information to be released to another healthcare provider as necessary for my care.

Patient signature

Date

(Criteria for eligibility: patient covered by Senior/FA/Private NH Program on 3+ chronic medications orpatient covered by Diabetes Program on 1+ treatment)

INFORMATION ABOUT MY HEALTH

Birthdate

◯Yes ◯No Smoking: If yes, # cigarettes/day

◯Yes ◯No Other Nicotine/Drugs

◯Yes ◯No Alcohol: if yes, # drinks/week

◯Yes ◯No Caffeine intake: # cups/day

◯Yes ◯No Drug Allergy (list with reactions):

◯Yes ◯No Kidney Disease?

◯Yes ◯No Liver Disease?

◯Yes ◯No Tetanus immunization (every 10 years)?

◯Yes ◯No Influenza immunization yearly?

◯Yes ◯No Pneumococcal immunization (one/life)?

◯Yes ◯No Herpes zoster immunization?

◯Yes ◯No Other immunizations/travel vaccines:

Medical Conditions:

What is your biggest concern about your medication today?

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Canadian Pharmacists Association / Association des pharmaciens du Canada

Prince Edward Island Pharmacists Association

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2. MEDICATION REVIEW INTERVIEW FLOW CHART

FOR USE BY PHARMACIST

Patient Name _____

PART A: For each medication, review the following information.

	Reviewed	Comments/Issues/Intervention	Follow-up
Knows generic and common brand name	☐		◯Yes ◯No
Knows reason(s) for use	☐		◯Yes ◯No
Understands dosing frequency	☐		◯Yes ◯No
Understands special dosing instructions (e.g., empty stomach, under the tongue)	☐		◯Yes ◯No
Assess adherence	☐		◯ Yes ◯No
Demonstrations, if applicable (e.g., inhalers, eye drops)	☐		◯Yes ◯No

PART B: General Knowledge

Check labelling & packaging (e.g., need for easy open vials or blister packs, trouble reading labels)	☐		◯Yes ◯No
Storage is appropriate	☐		◯Yes ◯No
Check expiry dates and discuss disposal of discontinued or expired medications	☐		◯Yes ◯No

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3. MEDICATION REVIEW INTERVIEW WORKSHEET

FOR USE BY PHARMACIST

Use the comments from the Medication Review Interview Flowchart to develop key medication issues, actions and follow-up. The "PharmaCheck Guide" may be a useful tool in addressing medication issues identified. Pharmacists should become familiar with the tips provided as an aid in addressing these issues.

Patient Name

Date of Medication Review

Pharmacist

Meds brought to visit (not on profile)

Issues

Actions

Follow-up

Follow-up appointment needed? ◯ Yes: Date/Time ◯ No

To complete the PharmaCheck Medication Review please complete the Personal Medication Record and Prescriber Communication Letter forms.

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4. MEDICATION REVIEW FOLLOW-UP

FOR USE BY PHARMACIST

Patient Name

Date of Birth PHN

Date of follow-up	Issues for follow-up	Pharmacist intervention and outcome	Further follow-up required (date/time)	No further follow-up	Pharmacist name
				☐	
				☐	
				☐	
				☐	

Where appropriate, please complete a new Personal Medication Record and/or Prescriber Communication Letter form.