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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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[ ]  No changes were made.