**Medicine Review Form**

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

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

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

1. How many prescription medicine containers did the patient bring in?

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2. Did the patient say he/she brought in **all** of his/her prescription medicine containers?

[ ]  Yes, patient said he/she brought in **all** of his/her prescription medicine containers

[ ]  No, patient said he/she brought in **some** of his/her prescription medicine containers, but not all of them

[ ]  No, patient did not bring in any of his/her prescription medicines and supplements

[ ]  I did not check whether the patient brought in all prescription medicine containers

3. How many prescription medicines did you review with the patient?

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

4. Did the patient say he/she brought in **all** of his/her over-the-counter medicines and supplements?

[ ]  Yes, patient said he/she brought in **all** of his/her over-the-counter medicines and supplements

[ ]  No, patient said he/she brought in **some** of his/her over-the-counter medicines and supplements, but not all of them

[ ]  No, patient did not bring in any of his/her over-the-counter medicines and supplements

[ ]  The patient does not have any over-the-counter medicines or supplements

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

5. Did you ask the patient what each medicine you reviewed was for (i.e., why he/she should take it)?

[ ]  Yes

[ ]  No (Skip to question 7)

6. Was the patient able to tell you the correct reason for taking each medicine?

[ ]  Yes

[ ]  No

**Medicine Review Form** (continued)

7. Did you ask the patient how and when he/she should take each of the medicines you reviewed?

[ ]  Yes

[ ]  No (Skip to question 9)

8. Was the patient able to tell you correctly how and when each medicine should be taken?

[ ]  Yes

[ ]  No

9. Were problems found with the patient’s medicine regimen?

[ ]  Yes

[ ]  No (Skip to question 13)

10. 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

[ ]  Drug-drug interactions could be possible

[ ]  Medicine was correct, but dose was incorrect

[ ]  Patient stopped taking a prescription medicine without telling you or any other clinician in this practice

[ ]  Patient stopped taking an over-the-counter medicine or supplement without telling you or any other clinician in this practice

[ ]  Patient started taking a new prescription medicine (i.e., prescribed by another doctor, prescription samples) without telling you or any other clinician in this practice

[ ]  Patient started taking a new over-the-counter medicine or supplement without telling you or another clinician in this practice

[ ]  Containers brought in by patient did not match the medicine list in the patient’s record

[ ]  Patient not taking medicine as prescribed

[ ]  Patient failed to get medicine refilled

[ ]  Patient changed to cheaper medicine

[ ]  Other – Please specify:

**Medicine Review Form** (continued)

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

[ ]  Yes

[ ]  Possibly

[ ]  No

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

[ ]  Yes

[ ]  Possibly

[ ]  No

[ ]  Not applicable (patient not experiencing negative symptoms)

13. Were changes made to the medicine regimen because of the review?

[ ]  Yes

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

14. Did the total number of prescription medicines change as a result of the review?

[ ]  Yes, the number of medicines was **reduced**

[ ]  Yes, the number of medicines was **increased**

[ ]  No, the number of medicines remained the same

15. What other changes were made to the medicine regimen? Please mark all that apply.

[ ]  Expired medicines were discontinued (thrown away)

[ ]  Updated prescriptions were written for expired medicines

[ ]  Alternate medicines were prescribed to replace existing medicines

[ ]  New medicines were prescribed

[ ]  Medicine regimen was simplified (e.g., fewer doses per day)

[ ]  Other – Please specify: