**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?

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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: