

Comprehensive Medication Review



Patient Information												Please rank the following statements 1 through 6 1 = most important 6 = least important	<input type="checkbox"/> Avoiding medicine side effects <input type="checkbox"/> Organizing my medications <input type="checkbox"/> Reducing my medication expenses <input type="checkbox"/> Reducing/managing my symptoms <input type="checkbox"/> Simplifying my daily dosing schedule <input type="checkbox"/> Using generic medications
Patient ID Number				Gender		Date of Birth							
				M F		Y Y Y Y M M D D							
Patient Last Name													
Patient First Name						Date of Review							
						Y Y Y Y M M D D							

Patient Health Care Priority			For Pharmacist Use Only		
Comfort <input type="checkbox"/> Avoiding medicine side effects is important to me. Reducing/managing my symptoms is important to me.	Convenience <input type="checkbox"/> Simplifying my drug therapy is important to me. Organizing my medication is important to me.	Cost <input type="checkbox"/> Reducing my medication expenses is important to me. Using generic medications is important to me.			

Patient Disease States									
<input type="checkbox"/> Asthma/COPD	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Thyroid Disorder					
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> GERD/PUD	<input type="checkbox"/> Hypertension	<input type="checkbox"/> OA/RA	<input type="checkbox"/> Other _____					
<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Mental Health Condition	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other _____					

Patient Medications						
Name/Strength	Indication	Regimen	How do you take	Duration	Efficacy/Complications	Prescriber
Patient Concerns/Notes						
Patient Concerns/Notes						
Patient Concerns/Notes						
Patient Concerns/Notes						
Patient Concerns/Notes						
Patient Concerns/Notes						

Patient Medications (cont.)

Name/Strength	Indication	Regimen	How do you take	Duration	Efficacy/Complications	Prescriber
Patient Concerns/Notes						
Patient Concerns/Notes						
Patient Concerns/Notes						
Patient Concerns/Notes						
Patient Concerns/Notes						
Patient Concerns/Notes						

Patient Untreated Conditions

What conditions do you have that you feel are being inadequately treated? _____

Pharmacist Assessment

Drug	Drug Therapy Problem	Patient Consultation	Prescriber Consultation	Encounter Claim #
		<input type="checkbox"/> Patient accepts therapy change <input type="checkbox"/> Patient rejects therapy change	<input type="checkbox"/> Prescriber accepts therapy change <input type="checkbox"/> Prescriber rejects therapy change	
		<input type="checkbox"/> Patient accepts therapy change <input type="checkbox"/> Patient rejects therapy change	<input type="checkbox"/> Prescriber accepts therapy change <input type="checkbox"/> Prescriber rejects therapy change	
		<input type="checkbox"/> Patient accepts therapy change <input type="checkbox"/> Patient rejects therapy change	<input type="checkbox"/> Prescriber accepts therapy change <input type="checkbox"/> Prescriber rejects therapy change	
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