

[Comprehensive Medication Review]

Patient Information

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

Patient Health Care Priority

For Pharmacist Use Only

<p>Comfort <input type="checkbox"/></p> <p>Avoiding medicine side effects is important to me. Reducing/managing my symptoms is important to me.</p>	<p>Convenience <input type="checkbox"/></p> <p>Simplifying my drug therapy is important to me. Organizing my medication is important to me.</p>	<p>Cost <input type="checkbox"/></p> <p>Reducing my medication expenses is important to me. Using generic medications is important to me.</p>
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Patient Disease States

A <input type="checkbox"/> Asthma/COPD	D <input type="checkbox"/> Diabetes	G <input type="checkbox"/> Hyperlipidemia	J <input type="checkbox"/> Migraine Headaches	M <input type="checkbox"/> Thyroid Disorder
B <input type="checkbox"/> Cardiovascular Disease	E <input type="checkbox"/> GERD/PUD	H <input type="checkbox"/> Hypertension	K <input type="checkbox"/> OAR/A	N <input type="checkbox"/> Other_____
C <input type="checkbox"/> Depression	F <input type="checkbox"/> Heart Failure	I <input type="checkbox"/> Mental Health Condition	L <input type="checkbox"/> Osteoporosis	O <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	
		<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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