# **UBC** Pharmacists Clinic

Prepared by: Prepared on:

Faculty of Pharmaceutical Sciences - Pharmacists Clinic

Second Floor, 2405 Wesbrook Mall Vancouver, BC V6T 1Z3 Phone: 604-827-2584 Fax: 604-827-2579

PATIENT									
First and Last Name:		PHN:		Gender:					
		Date of Birth:		Phone #:					
Known allergies and reactions:									
FAMILY PHYSICIAN									
Full Name:		Phone #:		Fax #:					

### BEST POSSIBLE MEDICATION HISTORY (BPMH)—Patient Section

MEDICATIONS I TAKE—Prescription, non-prescription, natural health products -								
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WHAT I TAKE	HOW I TAKE IT	WHY I TAKE IT	SPECIAL					
Name, strength & form of medication as noted on the	For example, when to take it, take with/without food,	Disease, condition or symptoms it	INSTRUCTIONS					
prescription or medication package label	warnings, etc.	addresses	(if applicable)					
<ul> <li>Patient was asked and is taking the non-prescrip</li> </ul>	otion or natural health products listed above, or otherwise no	I It taking any at this time						

Notes:

PATIENT ACKNOWLEDGEMENT					
My pharmacist has explained to me the purpose of a medication review service. I agreed that I could benefit from this publicly funded service. The review was conducted in a place that respected my privacy. During the appointment my pharmacist fully explained any medication changes or concerns to me. At the end of the medication review appointment, my pharmacist gave me a list of my current medications. The list includes any changes resulting from the medication review service provided.					
Signature of patient (or patient's legal representative)	Date				

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PATIENT								
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FAMILY PHYSICIAN								
Full Name:		Phone #:		Fax #:				

### BEST POSSIBLE MEDICATION HISTORY (BPMH)—Health Care Professionals Section

CLINICAL NEED FOR SERVICE								
Prescriber:	rec	quested a m	edication review					
Patient: (check one or more) has multiple diseases has one or more chronic dise has a medication regimen tha one or more non-prescription m	nat ases   at includes   ledications	ural health phas a drug th has a drug th has been rec has multiple	nerapy problem cently discharged from ho	spital	due to a su medication e to implem	, for an MR-F (Follow-up), follow-up is: (Check one) due to a subsequent medication change (i.e, a change in a edication entered on PharmaNet), or to implement and /or evaluate patient's response to the tion taken to resolve a DTP.		
<b>CURRENT MEDICATIONS</b>								
NAME OF DRUG & STREI	NGTH	PROFES For examp	IBER NAME & SION le, physician/MD, RPN, h, pharmacist, patient			N nple: Drug Therapy plan, referral, follow red	NOTES (if applicable)	
CLINICALLY RELEVANT MED	CLINICALLY RELEVANT MEDICATIONS THE PATIENT IS NO LONGER TAKING							
NAME & STRENGTH OF DRUG			MOST RECENT REGIMI	N WHO STOPPED IT  Name of prescriber, pharmacist, other	r or patient	COMMENTS r patient Reason for stopping, effectiveness, other relevant information		
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Notes:

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**PATIENT** 

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First and				PF	IN:				Gender:		
Last Name:				Date					Phone #:		
Kaassa allassa				Bir	th:					<u> </u>	
	es and reactions:										
FAMILY PHYS	ICIAN							Ī			
Full Name:				Phone	: #:				Fax #:		
			DF	UG THERAP	Y P	ROBLEM (DTP)	)				
DRUG THERA	DRUG THERAPY PROBLEM (select one only)										
	sary drug		dosage too low	adverse o				ineffect	ive drug		
	dditional drug		dosage too high		patient adherence						
MEDICATION	INVOLVED (drug nam	ie, route	e, dose, frequency, duration								
PLAN (what is the	ne issue, what will be dor	ne to res	solve the problem, by whom	and when)							
ACTION BY PHARMACIST (select all that apply)											
adapt pr	escription		contact	prescriber to cha	ange	/start/stop (Rx)			provide educ	ation	
	zation (public)			start/stop (non					initiate monitoring		
	zation (private)			te patient barrie					refer to medical physician		
refer to other health professional other recommendation (specify)											
FOLLOW UP (meeting date, pharmacist name, results/comments)											
NOTIFICATIO	N, if applicable (noti	fication	dates, persons notified)								