**Domiciliary Medication Management Review (DMMR)**

**RE: Dr Makeyou Well**

**DOB: 04/09/1940 (82yrs old)**

**Address: 123 Fake Street, Southport**

**Medicare Number: 4111 111 111 2**

**From:**

**Accredited Pharmacist:** Amanda Nematalla

**Preparing a HMR Report for:** Dr Makeyou Well

**Community Pharmacy if known:**  AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

**Preferred contact point:** amanda.nematalla@gmail.com or 0421596633

**To:**

**General Practitioner:** AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

**Provider number:** 12345MW

**Preferred Contact:** Phone: 0755123321 or Email:

**Interview date:**

**Request date:** AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

**Reason for referral:** AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

**Current medical conditions:**

2012 TIA  
13/12/2022 COVID-19 infection

**Table 1: Medication Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Condition, DOSE & Duration of treatment according to Patient** | **Issues / Findings/any problems or patient concerns** | **Recommendations**  (including issues resolved during visit) | **Management Plan (to be completed by GP)** |
| medication\_1 | med\_dosage\_1 |  |  |  |
| medication\_2 | med\_dosage\_2 |  |  |  |

During the interview I discussed each of the patient’s medicines, including indication, how each medicine works and common adverse effects to be aware of.

Height: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Weight: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Blood pressure at time of appointment: AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA

Creatinine = AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAumol/l

CrCl = AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA (adjusted for ideal body weight)

Unable to comment on renal/hepatic function due to lack of blood test results in referral

Allergies/smoking history/caffeine/alcohol consumption soft drink/water

**Symptoms**

|  |  |  |  |
| --- | --- | --- | --- |
| Pain | Headache | Dizziness | Falls |
| Constipation | Diarrhoea | Bladder | Nausea  Indigestion |
| Insomnia/Daytime Drowsiness | Ankle swelling | Short of breath | Bruising/ Sores |
| Itchiness | Muscle pain | Lack of appetite | Mobility |
| Vision | Hearing | Memory | Changes in mood |
| Joint problems | Anxiety | Swallowing problems | Fatigue/daytime drowsiness |

QUESTIONS:

* How often do you forget to take your medicines? Which ones in particular?

**Patient concerns:**

**Advisable to check in next blood test:**

* Cholesterol levels, Calcium/Vitamin D, Vitamin B12, Magnesium, Creatine Kinase, ALT/AST

Overall, the patient was very appreciative of being referred by you to have a home medicines review conducted. I have suggested slight alterations to their therapy as mentioned in this letter. If there is anything that you would like to discuss further or would like further evidentiary support for any of my statements, please do not hesitate to contact me. I look forward to collaborating further with you.

This report may qualify for a follow-up consultation with the patient due to ongoing high risk of medication related problems.

\*please note that the advice provided in this report is without knowing the full medical history of the patient. I understand that there may be sound clinical reasons why my recommendations may not be appropriate. Please contact me if further clarification is required. Any treatment decisions based on this information should be made in the context of the individual clinical circumstances of the patient.

**Kind regards,**

