Pharmacare
Pharmacy Rx

PHARMACARE SERVICES CONSENT FORM

Name of Client: _____ ☐ M ☐ F **D/O/B:** _____

Phone: _____ **Name of Site/Program/Clinic:** _____

Please read the following terms and conditions:

- For the remainder of the consent, the word "I" or "my" will be used and will be interchangeable with "the agent" and his/her consent where an agent is in place.
- I agree to utilize the services of Pharmacare Pharmacy for medications and related products and consent to their Clinical Pharmacist consultative services.
- Clinical Pharmacist services include but are not limited to: Annual Care Plans (Standard Medication Management Assessment, Comprehensive Annual Care Plan) and Follow-ups, Therapeutic Drug Substitution and/or Dose Adjustment for Organ Function, Renewal of Prescription, Injection Services, Prescribing at Initial Access, Managing Ongoing Therapy, Emergency Prescribing, Trial Prescriptions and Refusal to Fill a Prescription due to Overdose Risk, Abuse or Fraudulent Purposes as per the Alberta College of Pharmacists Standards of Practice.
- I understand the pharmacist will conduct an assessment for the purposes of completing an annual pharmacy care plan and/or medication assessment, in accordance with the requirements set out in the Alberta Health Compensation Plan for Pharmacy Services.
- Annual care plans require the pharmacist to conduct medication reviews one-on-one. If I am not available I consent to have a licensed health care professional act as a witness at that time. I will be able to follow up with the pharmacist if I have questions regarding their findings.
- I understand that copies of annual care plans and medication assessments will be offered and provided to me, as well as placed in the patient care file/chart as appropriate and will be available to me at any time by contacting the pharmacy.
- I understand that all medications and related products will be obtained by the preferred pharmacy and if other medications are purchased elsewhere they will not be repackaged as per Alberta College of Pharmacists Regulations.
- I understand that a Pharmacare prescribing pharmacist may prescribe and/or dose Tamiflu, in alignment with site policy and at no additional cost, for prophylaxis or treatment in the event of a declared public health influenza A outbreak.
- I agree to pay all charges incurred that are not paid for by a third party payor, including Blue Cross, within the 30 day term.
- I understand that medications are by law not refundable or returnable under any circumstance and as such cannot be returned for credit.
- I understand that certain home health care products cannot be returned for refund due to health and safety standards.
- I understand that the pharmacist is actively involved in the care of the resident and will access, request or disclose health information for the purpose of providing care to the resident.
- I understand that (where applicable) the pharmacist may round with physicians or other prescribers in my room and is actively involved in the multidisciplinary team of healthcare professionals.
- I consent to the release of personal and medical information to any third party payor, government agency providing benefits, or other person(s)/entity liable for my treatment charges.
- I consent to a similar release of information, as shall be necessary, to initiate and continue pharmacy care or laboratory care.
- I consent to have my picture on the blister pack for easy identification purposes, where dispill blister packs are used, eMAR software or other medication packaging and administration tools for easy identification purposes.

Date: _____

Name of Client: _____

Agent (if applicable): _____

Work Ph#: _____

Cellular Ph#: _____

Email: _____

Signature (Resident): _____

Signature (Agent): _____

Witness (Name): _____

Witness (Signature): _____

Please fax the completed form to Pharmacare Pharmacy || FAX: 780-444-9305

Pharmacare Fulfillment Centre || #100 – 17969 106 Ave || Edmonton, AB T5S 2H1 || Phone: 780-444-3257

proudly a division of Centric Health

Pharmacare Pharmacy Rx

PHARMACARE FINANCIAL GROUP: CLIENT BILLING INFORMATION FORM

Internal Use Only

Client Name: _____ **Facility:** _____

Billing information: Please enter the information for person who is responsible to make payments for your account; if it is yourself, please put "SELF" for name.

Name: _____ **Relationship to Client:** _____

Daytime Phone: _____ **Home Phone:** _____

Billing Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Email: _____ **Fax:** _____

Method of Payment

Our terms are net 21 days and if any special term is required, you will have to arrange them with our Accounts Specialists. For your convenience, we offer the following payment options:

1. Pre-authorized debit payment
2. Pre-authorized credit card payment
3. Cheque/Cash net 21 days
4. Payment by telephone please call 780-444-3257 ext.3

☐ Pre-authorized Bank Account Debit (**copy of void cheque required**)

Bank Account #: _____

Branch #: _____ (up to 5 digits) Institution: _____ (3 digits)

☐ Pre-authorized Credit Card (Visa, MasterCard, and American Express)

Credit Card #: _____

Expiry (MM/YY): _____ Security #: _____ (3 digits on back or 4 digits on front for AMEX)

Name on Credit Card: _____

I/we authorize my/our financial institution to debit my/our account on (or after) the withdrawal date of each invoice for all amount owing to Pharmacare Pharmacy Financial Group. This authorization is valid for either the bank account or the credit card account specified above, or any other account which I/we may designate in the future in lieu of the account specified above. I/we understand that in the event that a payment is returned by the bank for any reason, that I/we will be responsible for NSF and/or $25 administration charges.*

I/we have certain recourse rights if any debit does not comply with this agreement. I/we have the right to receive reimbursement for any debit that is not authorized or is not consistent with this pre-authorized agreement. I/we may cancel this agreement at any time by providing written notice to the address below by contacting Pharmacare Pharmacy Financial Group at 780-444-3257 EXT.3 at least (15) fifteen days before the next scheduled withdrawal date. (the withdrawal date is currently on (or after) the 29th of every month)*

Client Signature: _____ Date: _____

*Please **fax with a void cheque** to Pharmacare Financial Group: **FAX: 780-784-2844***
Mail: PO Box 25503, Edmonton, AB T5T 7E7 || Email: billings@mypharmacare.ca

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PHARMACY ADMISSION FORM

PERSONAL INFORMATION

First Name:_____ Middle Initial:_____ Surname:_____

Date of Birth:_____ ☐ Male ☐ Female Personal Healthcare #: _____

Address_____ Postal Code: _____

Resident Phone Number:_____ Cellphone Number: _____

Drug insurance Type: _____ ID #:_____ Group #:_____

Diagnosis:_____ Allergies:_____

Family Doctor: _____ Phone: _____ Fax: _____

Specialist: _____ Phone: _____ Fax: _____

Do you pay your own bills? ☐ Yes ☐ No

If NO, please indicate: _____ (Name) _____ (Relationship) _____ (Phone: home/business)

Emergency Contact: _____ (Name) _____ (Relationship) _____ (Phone: home/business)

Are you on Home Care with medication assistance? ☐ Yes ☐ No
OR
Are you on a medication assistance program through the community? ☐ Yes ☐ No

Independent – do you take your own medications? ☐ Yes ☐ No

If independent client (no medication assistance), please check the type of packaging you prefer:
☐ Blister ☐ Tear-able ☐ Dosette ☐ Reg Vials ☐ Child Proof ☐ 3 Months' Supply

Comments:

HEALTH COVERAGE		
Type of Plan	**Card Number**	**Single/Family**
Alberta Blue Cross		
2nd Blue Cross Plan		
Social Services		
Other: DVA/AISH, etc.		

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Pharmacare Fulfillment Centre || #100 – 17969 106 Ave || Edmonton, AB T5S 2H1 || Phone: 780-444-3257

Centric Health

Alberta Health Services

Affix patient label within this box

Goals of Care Designation (GCD) Order

Date *(yyyy-Mon-dd)*	Time *(hh:mm)*

Goals of Care Designation Order

To order a Goals of Care Designation for this patient, check the appropriate Goals of Care Designation below and write your initials on the line below it. *(See reverse side for detailed definitions)*

Check ▶	☐ **R1**	☐ **R2**	☐ **R3**	☐ **M1**	☐ **M2**	☐ **C1**	☐ **C2**
Initials ▶	_____	_____	_____	_____	_____	_____	_____

Check ✓ here ☐ if this GCD Order is an interim Order awaiting the outcome of a Dispute Resolution Process. Document further details on the ACP/GCD Tracking Record.

Specify here if there are specific clarifications to this GCD Order. Document these clarifications on the ACP/GCD Tracking Record as well.

_____

_____

_____

_____

Patient's location of care where this GCD Order was ordered *(Home; or clinic or facility name)*

Indicate which of the following apply regarding involvement of the Patient or alternate decision-maker (ADM)

☐ This GCD has been ordered after relevant conversation with the patient.

☐ This GCD has been ordered after relevant conversation with the alternate decision-maker (ADM), or others. *(Names of formally appointed or informal ADM's should be noted on the ACP/GCD Tracking Record)*

☐ This is an interim GCD Order prior to conversation with patient or ADM.

History / Current Status of GCD Order

Indicate one of the following

☐ This is the first GCD Order I am aware of for this patient.

☐ This GCD Order is a revision from the most recent prior GCD *(See ACP/GCD Tracking Record for details of previous GCD Order)*.

☐ This GCD Order is unchanged from the most recent prior GCD.

Name of Physician / Designated Most Responsible Health Practitioner who has ordered this GCD	Discipline
Signature	Date *(yyyy-Mon-dd)*

Goals of Care Designations – Guide for Clinicians

R: Medical Care and Interventions, Including Resuscitation if required followed by Intensive Care Unit admission.

Focus of Care and interventions are for cure or control of the Patient's condition. The Patient would desire and is expected to benefit from attempted resuscitation and ICU care if required.

R1: Patient is expected to benefit from and is accepting of any appropriate investigations/interventions that can be offered including attempted resuscitation and ICU care.

- **Resuscitation:** is undertaken for acute deterioration, and may include intubation and chest compression
- **Life Support Interventions:** are usually undertaken
- **Life Sustaining Measures:** are used when appropriate
- **Major Surgery:** is considered when appropriate.
- **Transfer:** is considered for diagnosis and treatment, if required

R2: Patient is expected to benefit from and is accepting of any appropriate investigations/interventions that can be offered including attempted resuscitation, intubation and ICU care, but excluding chest compression

- **Resuscitation:** is undertaken for acute deterioration, but chest compression should not be performed
- **Life Support Interventions:** may be offered **without** chest compression
- **Life Sustaining Measures:** are used when appropriate
- **Major Surgery:** is considered when appropriate
- **Transfer:** is considered for diagnosis and treatment, if required

R3: Patient is expected to benefit from and is accepting of any appropriate investigations/interventions that can be offered including attempted resuscitation and ICU care, but excluding intubation and chest compression

- **Resuscitation:** is undertaken for acute deterioration but intubation and chest compression should not be performed
- **Life Support Interventions:** may be offered **without** Intubation and **without** chest compression
- **Life Sustaining Measures:** are used when appropriate
- **Major Surgery:** is considered when appropriate
- **Transfer:** is considered for diagnosis and treatment, if required

M: Medical Care and Interventions, Excluding Resuscitation.

Focus of Care and interventions are for cure or control of the Patient's condition. The Patient either chooses to not receive or would not be expected to benefit from attempted resuscitation followed by life-sustaining care in an ICU. In Pediatrics, ICU can be considered if that location is deemed the best location for delivery of specific short-term symptom-directed care.

M1: All clinically appropriate medical and surgical interventions directed at cure and control of condition(s) are considered, excluding the option of attempted life-saving resuscitation followed by ICU care. See above, regarding Pediatrics and ICU.

- **Resuscitation:** is **not** undertaken for cardio respiratory arrest.
- **Life Support Interventions:** should **not** be initiated, or should be discontinued after discussion with the Patient.
- **Life Sustaining Measures:** are used when appropriate.
- **Transfer:** to another location of care is considered if that location provides more appropriate circumstances for diagnosis and treatment
- **Major Surgery:** is considered when appropriate. Resuscitation during surgery or in the recovery room can be considered, including short term physiologic and mechanical support in an ICU, in order to return the Patient to prior level of function. The possibility of intra-operative death or life-threatening deterioration should be discussed with the Patient in advance of the proposed surgery and general decision-making guidance agreed upon and documented.

M2: All clinically appropriate interventions that can be offered in the current non-hospital location of care are considered. If a patient does not respond to available treatments in this location of care, discussion should ensue to change the focus to comfort care. Life-saving resuscitation is not undertaken except in unusual circumstances (see below in Major Surgery). See above, regarding Pediatrics and ICU.

- **Resuscitation:** is **not** undertaken for cardio respiratory arrest.
- **Life Support Interventions:** should **not** be initiated, or should be discontinued after discussion with the Patient.
- **Life Sustaining Measures: are** used when appropriate.
- **Transfer:** is not usually undertaken, but can be contemplated if symptom management or diagnostic efforts aimed at understanding symptoms can be best undertaken at that other location.
- **Major Surgery:** can be considered, in order to prevent suffering from an unexpected trauma or illness. Resuscitation during surgery or in the recovery room can be considered, including short term physiologic and mechanical support in an ICU, in order to return the Patient to prior level of function. The possibility of intra-operative death or life-threatening deterioration should be discussed with the Patient in advance of the proposed surgery and general decision-making guidance agreed upon and noted as special circumstances on the GCD Order Form and Tracking Record.

C: Medical Care and Interventions, Focused on Comfort.

Focus of Care and interventions are for the active palliative treatment of the Patient who has a terminal illness, and support for those close to them. This includes medical care for symptom control and psychosocial and spiritual support in advance of death. Care can be provided in any location best suited for these aims, including an ICU, a Hospice or any location that is the most appropriate for symptom-based care for this particular Patient.

C1: All care is directed at maximal symptom control and maintenance of function without cure or control of an underlying condition that is expected to cause eventual death. Treatment of intercurrent illnesses can be contemplated only after careful discussion with the Patient about specific short-term goals.

- **Resuscitation:** is not undertaken.
- **Life Support Interventions:** should **not** be initiated, or should be discontinued after discussion with the Patient.
- **Life Sustaining Measures: are** used only for goal directed symptom management.
- **Major Surgery:** is not usually undertaken, but can be contemplated for procedures aimed at symptom relief. Resuscitation during surgery or in the recovery room can be considered, including short term physiologic and mechanical support in an ICU, in order to return the Patient to prior level of function, but this would be a rare circumstance. The possibility of intra-operative death or life-threatening deterioration should be discussed with the Patient in advance of the proposed surgery and general decision-making guidance agreed upon and documented.
- **Transfer:** to any appropriate location of care can be considered at any time, to better understand or control symptoms.

C2: All care is directed at preparation for imminent death [usually within hours or days] with maximal efforts directed at symptom control.

- **Resuscitation:** is not undertaken.
- **Life Support Interventions:** should not be initiated, or should be discontinued after discussion with the Patient.
- **Life Sustaining Measures:** should be discontinued unless required for symptom management.
- **Major Surgery:** is not appropriate.
- **Transfer:** is usually not undertaken but may be considered if required.

Note that specific interventions can be acceptable acts within multiple Goals of Care Designations. It is the goal or intention of the intervention that determines consistency with a Designation.

Life Support Interventions mean interventions typically undertaken in the Intensive Care Unit but which occasionally are performed in other locations in an attempt to restore normal physiology. These may include chest compressions, mechanical ventilation, defibrillation, other resuscitative measures, and physiological support.

Life Sustaining Measures mean therapies that sustain life without supporting unstable physiology. Such therapies can be used in multiple clinical circumstances. When viewed as life sustaining measures, they are offered in either a) the late stages of an illness in order to provide comfort or prolong life, or b) to maintain certain bodily functions during the treatment of intercurrent illnesses. Examples include enteral tube feeding and parenteral hydration.

Resuscitation means the initial effort undertaken to reverse and stabilize an acute deterioration in a Patient's vital signs. This may include chest compressions for pulselessness, mechanical ventilation, defibrillation, cardioversion, pacing, and intensive medications. Patients who have opted to not have chest compressions and/or mechanical ventilation may still be considered for other resuscitative measures (see Designation R3).

In the above descriptions, when indicating "discussions with the Patient", it is to be assumed that this means a capable Patient, a Mature Minor, or a designated Alternate Decision Maker (ADM). If a patient is incapable and there is no designated ADM, appropriate people within the patient's close circle can be consulted.

103547(Rev2014-01)

RESIDENT RECORD - ACCOUNTING

MOVE-IN DATE: _____ SUITE #: _____

LAST NAME: _____ FIRST NAME: _____

LAST NAME: _____ FIRST NAME: _____

MONTHLY RENTAL FEE: $ _____ PAP SUBMITTED ☐

2ND OCCUPENT FEE: $_____ TOTAL MONTHLY RENT: $_____

SL4 ☐ SL4D ☐ INDEPENDENT ☐

MONTHLY STATEMENT TO BE SENT TO RESIDENT ☐ OTHER ☐

PRINT NAME AND ADDRESS BELOW:

_____

_____

ADDITIONAL SERVICES **DATE:** _____ **START** ☐ **STOP** ☐

LAUNDRY $ _____ RENT(SEE ABOVE): $_____

PARKING STALL # _____ $ _____

CABLE $ _____

OTHER _____ : $ _____

OTHER _____ : $ _____

TOTAL ADDITIONAL SERVICES

TOTAL MONTHLY CHARGES: $_____

FIRST MONTH CALCULATION:

# of days in current month _____ (A) # of days renting this month _____ (B)

Total Monthly Charges $_____ X (B) _____ / (A)_____ = $ _____

COMMENTS:

_____

_____

_____

_____

_____

SIGNED BY: _____ _____

BUSINESS OFFICE MANAGER EXECUTIVE DIRECTOR

MACTAGGART RETIREMENT RESIDENCE

TASK SHEET
DEMENTIA CARE UNIT
DAYS/EVENINGS (GROUP 1)

Staff:
Assign Task: _____

Date: _____
Phone:

Resident's blinds/ Curtains need to be closed every night. Empty garbage bins in resident room before end of the shift. Sweep laundr room and keep tidy as well as clean out lint trap with every use of the dryer. Make sure all residents are changed into night wear and Dry before put into bed. Keep their rooms/ bathrooms clean and tidy when necessary. Ensure all their laundry is put away instead of staying in the hampers. Take and document water temperatures for each shower and inform the LPN and document ANY refusals. Provide and offer snack at every schedule

0SUITE #	NAME	BATH	LAUNDRY	OTHER	Med assist				NOTES
	Care Unit				0800	1200	1700	2000	

BATH SCHEDULE

	SUN	MON	TUE	WED	THUR	FRI	SAT
D							
E							

UPADATED: _____

RUTHERFORD HEIGHTS
DISPERSED DAL (DDAL/SL4)
LPN TASK SHEET

	NAME	0800	1200	1700	2100	Notes

RUTHERFORD HEIGHTS DISPERSED DAL (DDAL/SL4)

LPN TASK SHEET

Vit B12 Injection.	**Daily COUMADIN @ 2100h**
Other Injections	

PLEASE KEEP US UPDATED WITH ANY CHANGES IN THIS TASK SHEET. Please notify ED and Paul via EMAIL or in PERSON.

NOTIFY THE CASE MANAGER (through LPN-DAL Communication binder) AND AVAILABLE MANAGER/SUPERVISOR WITH ANY FALL & MEDICATION INCIDENTS PLEASE.

Thank you!

edeguzman@allseniorscare.com

rhrcc@allseniorscare.com

Updated: _____