Ontario

wMinistry of Health
and Long-Term Care

MedsCheck

Pharmacists Worksheet

MedsCheck Service Provided

Patient Information

Last Name		First Name	
Gender	Date of Birth (yyyy/mm/dd)	Health Card Number	Telephone Number

Patient Address

Unit Number	Street Number	Street Name	PO Box
City/Town		Province	Postal Code

Email Address

Date Patient Signed Annual Acknowledgement Form (yyyy/mm/dd)

Caregiver/Patient's Agent Information

Last Name	First Name
Telephone Number	Email Address

Notes

Primary Care Provider

Last Name	First Name	Designation
Telephone Number	Fax Number	Email Address

Known Allergies and Intolerances

☐ Select if there are no known allergies or intolerances

Interview Conducted At

☐ Pharmacy

Pharmacy Name

Unit Number	Street Number	Street Name	PO Box
City/Town		Province	Postal Code

☐ Patient's Home

Unit Number	Street Number	Street Name	PO Box
City/Town		Province	Postal Code

ONTARIO PHARMACISTS ASSOCIATION

Lifestyle Information

- ☐ Tobacco ☐ Yes ☐ No _____ cig/day
- ☐ Smoking Cessation status _____
- ☐ Recreational Drug Use ☐ Yes ☐ No Frequency _____
- ☐ Alcohol Use ☐ Yes ☐ No Frequency _____
- ☐ Exercise Regimen _____
- ☐ Other (Specify) _____

Lifestyle Information (notes)

Clinical Need for Service (notes)

Why are you [the pharmacist] conducting this MedsCheck service?

Patient Characteristics Contributing to the Need for the MedsCheck Service (Select all that apply)

- ☐ 3 or more chronic medications _____
- ☐ Multiple acute conditions and/or one or more chronic diseases _____
- ☐ Medication regimen that includes one or more non prescription medications _____
- ☐ Medication regimen that includes one or more natural health products _____
- ☐ Symptoms that seem unaddressed by current pharmacotherapy _____
- ☐ Potential drug therapy problem that may be prevented _____
- ☐ Multiple prescribers _____
- ☐ Issues relating to early +/or late refills _____
- ☐ Non-adherence _____
- ☐ Patient seems confused about medication regimen _____
- ☐ Medication(s) that require routine laboratory monitoring _____
- ☐ Abnormal lab results (blood work, creatinine clearance, etc) _____
- ☐ Planned admission to a hospital or other health institution (i.e. – long-term care facility)
- ☐ Discharge/transition from hospital to community or other healthcare institution (i.e. – long-term care facility)
- ☐ Initiating compliance packaging _____
- ☐ Known or suspected poor or unstable renal function _____
- ☐ Known or suspected poor or unstable liver function _____
- ☐ Other (Specify) _____

Sources Consulted to conduct this MedsCheck service

- ☐ Pharmacy Profile
- ☐ Physician / Nurse Practitioner
- ☐ Patient
- ☐ Caregiver / Agent
- ☐ Another Pharmacy
- ☐ Medication Packages
- ☐ Laboratory / Test Values
- ☐ Electronic Health Record
- ☐ Hospital / Other Facility
- ☐ Other (Specify)

Current Medication List (attach printed records if available. Information to populate MedsCheck Personal Medication Record where appropriate)

Medication 1

Name of Drug/Product (generic/brand)

Strength of Drug/Product

Dosage Form

Directions for Use	Indication	Adherence Issue ☐Yes ☐No	Rx? OTC? NHP?

Patient Comments (ie/ how they actually take it, side effects, etc.)

Pharmacist Notes (ie/ disposition of drug therapy problem, recommendations, etc.)

Comments for MedsCheck Record

Add Medication **Remove Medication**

Clinically Relevant Discontinued Medications (if applicable)

Medication 1

Name of Drug/Product, Strength, Dosage Form, Directions for use on Previous Record

Notes (if applicable)

Add Medication **Remove Medication**

Therapeutic Issues Identified (if applicable)

Therapeutic Issue 1

Suggested Therapy

Action Taken

Add Issue **Remove Issue**

Notes

Checklist for Completeness

- ☐ Asked about Rx medications from other individuals, MD samples, pharmacies and care providers
- ☐ List of meds removed from home if applicable
- ☐ Asked about OTC products purchased or obtained from another individual (including specifically ASA)
- ☐ Asked about herbal or natural health products purchased or obtained from another individual
- ☐ Prompted for specific dosage forms which are often forgotten (ie/ inhalers, topicals, eye drops, nasal sprays, patches, injectables, etc.)
- ☐ Asked about anti-infectives used in the last 3 months.
- ☐ Referenced attached notes, results, references as appropriate
- ☐ Discussed circle of care, sharing information with other providers and the patient's responsibility for providing accurate information
- ☐ Discussed anticipated date of completion of patient's MedsCheck Personal Medication Record (if not available at the time of the MedsCheck)
- ☐ Ensure clinically relevant information is documented and readily retrievable for continuity of care and for audit purposes
- ☐ Other (Specify)

Plan for Follow Up

☐ Healthcare providers with whom to communicate

Health Care Provider 1

Last Name	First Name

Health Related Specialty

Add Health Care Provider | Remove Health Care Provider

Summary and Goals (information to be added to the MedsCheck Patient Take-Home Summary)

Summary of today's discussion

Patient Goals

What I will Do to Get There

List of resources and contacts provided

Other Follow-up Planning and referrals

Prepared By

Pharmacist Full Name (Last Name, First Name)

OCP Number	Date of MedsCheck Review (MedsCheck is billed on the day of the consultation) (yyyy/mm/dd)
Appointment Time of MedsCheck Review	Date MedsCheck Documentation Completed (yyyy/mm/dd)