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 -*

WHAT I TAKE *Name, strength & form of medication as noted on the prescription or medication package label*	**HOW I TAKE IT** *For example, when to take it, take with/without food, warnings, etc.*	**WHY I TAKE IT** *Disease, condition or symptoms it addresses*	**SPECIAL INSTRUCTIONS** *(if applicable)*

☒ Patient was asked and is taking the non-prescription or natural health products listed above, or otherwise not 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

Attention Health Care Professionals: Sources of information in this document include (but are not limited to) PharmaNet, local pharmacy data and the patient. The patient is responsible for the accuracy and completeness of the data they provided when this document was prepared and for advising the pharmacist of any change to these medications. The pharmacist is responsible for information in this document that changed as a result of providing a medication review service to the patient.

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

CLINICAL NEED FOR SERVICE

Prescriber: requested a medication review

Patient: *(check one or more)*
- has multiple diseases
- has one or more chronic diseases
- has a medication regimen that includes one or more non-prescription medications
- has a medication regimen that includes one or more natural health products
- has a drug therapy problem
- has been recently discharged from hospital
- has multiple prescribers
- takes medication(s) that require laboratory monitoring

Or, for an MR-F (Follow-up), follow-up is: *(Check one)*
- due to a subsequent medication change (i.e, a change in a medication entered on PharmaNet), or
- to implement and /or evaluate patient's response to the action taken to resolve a DTP.

CURRENT MEDICATIONS

NAME OF DRUG & STRENGTH	**PRESCRIBER NAME & PROFESSION** *For example, physician/MD, RPN, naturopath, pharmacist, patient*	**VERIFIED** *Continue as per 1 = PHARMANET, 2 = PATIENT (different than PharmaNet), 3 = PATIENT (not in PharmaNet), 4 = PHYSICIAN*	**ACTION** *For example: Drug Therapy Problem plan, referral, follow up required*	**NOTES** (if applicable)

CLINICALLY RELEVANT MEDICATIONS THE PATIENT IS NO LONGER TAKING

NAME & STRENGTH OF DRUG	**WHY IT WAS TAKEN**	**MOST RECENT REGIMEN**	**WHO STOPPED IT** *Name of prescriber, pharmacist, other or patient*	**COMMENTS** *Reason for stopping, effectiveness, other relevant information*

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DRUG THERAPY PROBLEM (DTP)

DRUG THERAPY PROBLEM (select one only)

	unnecessary drug		dosage too low		adverse drug reaction		ineffective drug
	needs additional drug		dosage too high		patient adherence		

MEDICATION INVOLVED (drug name, route, dose, frequency, duration)

PLAN (what is the issue, what will be done to resolve the problem, by whom and when)

ACTION BY PHARMACIST (select all that apply)

	adapt prescription		contact prescriber to change/start/stop (Rx)		provide education
	immunization (public)		change/ start/ stop (non-Rx)		initiate monitoring
	immunization (private)		eliminate patient barrier		refer to medical physician
	refer to other health professional		other recommendation (specify)		

FOLLOW UP (meeting date, pharmacist name, results/comments)

NOTIFICATION, if applicable (notification dates, persons notified)