Ontario

Ministry of Health
and Long-Term Care

MedsCheck

Diabetes Education Patient Take-Home Summary

Patient Information

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

Pharmacy Name

Pharmacy Address

Unit Number	Street Number	Street Name	PO Box
City/Town	Province	Postal Code	
Telephone Number	Fax Number	Email Address (if available)	

Summary of Today's Discussion

My Goals

What I Will Do To Get There

List of Resources and Contacts Provided

Referrals Information

The MedsCheck Diabetes Education Program is a voluntary program sponsored by the Ontario government. I acknowledge that I have received the diabetes education referenced above from a licensed pharmacist in relation to my diabetes care. I understand that a record of this education may be shared with other health care professionals within the health care team.

Prepared By

Pharmacist Full Name (Last Name, First Name)

Date of Diabetes Education (yyyy/mm/dd)

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ONTARIO PHARMACISTS ASSOCIATION

Patient's Signature	Pharmacist's Signature