Ontario

Ministry of Health
and Long-Term Care

ONTARIO PHARMACISTS ASSOCIATION

MedsCheck

Personal Medication Record

MedsCheck Service Provided	Location (Pharmacy / Patient's Home)

Patient Information

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

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

Telephone Number	Date of Interview (yyyy/mm/dd)	Email Address

Sources Caregiver and/or Contact Name

Last Name	First Name	Telephone Number

Primary Care Provider

Last Name	First Name	Telephone Number	Fax Number

Current Medication List - Prescription, Non-Prescription, Natural Health Products

Known Allergies and/or Intolerances

☐ Select **only** if patient is **not** taking any non-prescription products (ie/ vitamins, natural health products, over-the-counter)

WHAT I TAKE Name, strength & form of medication as noted on the prescription or medication package label	**WHY I TAKE IT** Disease, condition or symptoms it addresses	**HOW I TAKE IT** Qty, route, times per day or certain time of day	**COMMENTS** eg. Special instructions; drug-related issues identified; prescriber (if different); etc.

Attention Health Care Professionals: A more detailed version of this MedsCheck Review that includes professional notes is available from the pharmacy named. Sources of information in this document include (but are not limited to) local pharmacy data and the patient. The patient has been informed of the intent of the MedsCheck Review and on what to expect. 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.

Pharmacy Name (and/or Logo/Label) and Address	MedsCheck Pharmacist Name		Pharmacy Telephone Number
	Pharmacist's Signature	Date MedsCheck Report Completed (yyyy/mm/dd)	Pharmacy Fax Number

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