Ontario

Ministry 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

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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)

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

Clinically Relevant Discontinued Medications (if applicable)

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

Notes (if applicable)

Therapeutic Issues Identified (if applicable)

Suggested Therapy

Action Taken

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

Last Name	First Name

Health Related Specialty

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)