Ontario

Ministry of Health
and Long-Term Care

MedsCheck

MedsCheck Patient Acknowledgement of Professional Pharmacy Service

To be completed annually for MedsCheck Professional Pharmacy Services (excluding MedsCheck for Long-Term Care Home residents). To be filed at the pharmacy for documentation and auditing purposes. Please cross-reference with accompanying MedsCheck reviews. Please provide a copy to the patient +/or patient's agent

Patient Information

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

Pharmacy Information

Pharmacy Name

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

MedsCheck reviews typically occur at the pharmacy where there is a sufficient level of privacy that ensures patient confidentiality. A pharmacy team member will explain which program is best suited to your needs; this form is completed annually at any pharmacy that provides the program. Professional Pharmacy Services may include:

☐ MedsCheck Annual ☐ MedsCheck Follow-up ☐ MedsCheck for Diabetes Annual ☐ Diabetes Education Follow-up

☐ MedsCheck at Home (also includes a medication cabinet clean-up and pharmacist disposal of unused medication from the patient's home with the patient's understanding)

- MedsCheck is a service that patients participate in voluntarily and is sponsored by the Ontario government.
- Information about the MedsCheck program is available on the Ontario government and Ontario Pharmacists Association websites and/or on the Government patient brochure.
- MedsCheck includes a completed MedsCheck Personal Medication Record that is signed and dated by the pharmacist. The completed MedsCheck form aims to resolve real or potential drug therapy related problems identified by you, the pharmacist or your primary care provider.
- The accuracy of the information on the final MedsCheck document depends on the accuracy and completeness of the information provided by the patient at the time the MedsCheck was performed.
- The completed MedsCheck document and this patient acknowledgement demonstrate that both parties have an understanding of the MedsCheck program and the process.
- As a member of your health-care team, your pharmacist may confidentially share the completed MedsCheck with other health care professionals to ensure that the relevant members of your health care team are up to date on your current medication profile. Exchange of the MedsCheck Personal Medication Review will be done so in a manner to ensure secure transfer of patient health information.

Patient Acknowledgement

By signing this form, you are acknowledging participation in an in-person MedsCheck medication review with a pharmacist associated with the pharmacy noted above. It may be necessary for the pharmacist to discuss and share your health information with other health care professionals (e.g., physicians, nurses, etc.) in accordance with generally accepted medication therapy management principles. Your signature below will indicate that you acknowledge the secure exchange of information and your agreement to the MedsCheck service.

Patient/ Agent Signature	Date (yyyy/mm/dd)

Comments

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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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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)

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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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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 Program is a voluntary program sponsored by the Ontario Government. The MedsCheck patient take-home summary may be offered to you in addition to your MedsCheck Personal Medication Record

Prepared By

Pharmacist Full Name (Last Name, First Name)

Date of MedsCheck Review (yyyy/mm/dd)

Patient's Signature	Pharmacist's Signature

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MedsCheck

Healthcare Provider Notification of MedsCheck Services

To _____ **Fax Number** _____

Telephone Number _____ **Pages** _____

Email Address **Date (yyyy/mm/dd)** _____

Re: Patient's Name _____

Patient's Address _____

Telephone Number _____

Our mutual patient noted above has had a MedsCheck completed by our pharmacist on _____
Date (yyyy/mm/dd)

The MedsCheck program aims to ensure that patients take medications as prescribed. It also aims to resolve or prevent any drug therapy problems identified by the patient or the pharmacist.

The resulting comprehensive **MedsCheck Personal Medication Record** is attached consolidating his/her prescription, non-prescription and natural health product profile.

This MedsCheck Personal Medication Record is for your reference and may be included as part of your patient's ongoing medical record.

Please see attached

Please take note of the following:

- ○ No follow-up issues have been identified at this time. The MedsCheck Personal Medication Record is an accurate assessment of the patient's prescription, non-prescription and natural health product usage at this current moment.
- ○ Follow-up issues have been identified with this MedsCheck review, and they have been summarized and are attached with this fax transmission.

Issues

Pharmacist Name	Pharmacist's Signature

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MedsCheck

Diabetes Education Checklist

This document represents a list of the different subjects including insulin education if applicable to be covered during MedsCheck diabetes education sessions; and should be addressed according to the patient's needs, learning capabilities and the pharmacist availability. This education is considered specialty training. Pharmacists providing this service are required to have adequate knowledge of diabetes education through a professional program that is CCCEP approved or a Certified Diabetes Educator designation.

Note** - See glossary for terms

Patient Information

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

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

Caregiver/Patient's Agent Information

Last Name	First Name
Telephone Number	Email Address

Primary Care Provider

Last Name		First Name
Telephone Number	Fax Number	Email Address

General Information

Stage of readiness for change

Identify Patient's Goals

My Goals (information placed here - to be added to Patient Take-Home Summary)

Insulin use ○ Yes ○ No

Oral Hypoglycemic Medications ○ Yes ○ No

Pharmacists Comments on Drug Therapy

☐ HbA1C* _____

☐ BP* (today's average) _____

☐ FPG* _____

☐ TC HDL ratio _____ LDL _____ HDL _____ TG _____

☐ Physical Activity _____ min/week

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☐ Weight _____ Height _____ Waist circumference _____ BMI* _____

☐ Cognitive function/learning impairments _____

☐ MedsCheck for Diabetes (Annual) available for review (attached) _____

☐ DTP identified and resolved (as per MedsCheck Diabetes (Annual) if applicable,) _____

☐ Tobacco ○ Yes ○ No _____ cig/day

☐ Smoking cessation offered _____

☐ Alcohol/recreational drugs _____ Frequency of use _____

☐ Dietary concerns _____

☐ Other (Specify) _____

General Diabetes Education – Lifestyle / Health & Wellness

☐ Management of Medications (Rx and OTCs / herbals / vitamins) _____

☐ Foot care discussion _____

☐ Screening for DN* _____

☐ Foot condition/ulcers _____

☐ Proper shoe fit _____

☐ BP* monitoring _____

☐ CV* and other risk factors _____

☐ Mental health assessment _____

☐ Erectile dysfunction/ sexual health _____

☐ Lifestyle:

- ☐ Diet _____
- ☐ Stress Reduction _____
- ☐ Exercise _____

☐ Eye health and reminder of yearly eye exam _____

☐ Dental hygiene _____

☐ Immunizations:

- ☐ Influenza _____
- ☐ Pneumococcal vaccine _____
- ☐ Other (Specify) _____

☐ Driving guidelines _____

☐ Travelling with diabetes _____

Self-Monitoring of Blood Glucose – Blood Sugar Management

- ☐ Meter training _____
- ☐ Testing frequency and Optimal schedule _____
- ☐ Recording of results (logbook given) _____
- ☐ Identification of patterns _____
- ☐ Prevention, Identification and Treatment of hypoglycemia _____
- ☐ Proper medication/supplies handling _____
- ☐ Training on use and disposal of diabetes supplies (needles, lancets) _____
- ☐ Sick Days Management and Ketones Testing _____
- ☐ Individualized BG* targets _____
- ☐ Other (Specify) _____

Specialty Training

- ☐ Insulin types/ duration of action _____
- ☐ Pen/ syringe handling _____
- ☐ Site preparation and inspection _____
- ☐ Injection training for GLP-1* _____
- ☐ Proper injection technique / site rotation _____
- ☐ Patient demonstrated use _____
- ☐ Dosage adjustments (BG* patterns management) _____
- ☐ Missed or skipped doses/ timing of injections _____
- ☐ Review of carbohydrate counting _____
- ☐ Emergency and sick day management _____
- ☐ Alcohol/ recreational drugs/ tobacco and insulin _____
- ☐ Updated Insulin Regimen:

Type _____ am _____ noon _____ supper _____

Type _____ HS _____ Other _____

- ☐ Other (Specify) _____
- ☐ Other complications discussed _____

Resources Provided

- ☐ Diabetes Passport (record of important lab tests) _____
- ☐ Sick days management plan _____
- ☐ After hours support/ contact information _____
- ☐ Directory of local community resources _____
- ☐ Other material given to the patient _____

Resource Information to be added to Patient Take-Home Summary

Referrals and Reason

- ☐ Endocrinologist _____
- ☐ Primary care physician _____
- ☐ Dietitian _____
- ☐ Nurse _____

☐ Family pharmacist _____

☐ Other _____

☐ _____
Follow-up date (yyyy/mm/dd)

Purpose

Referral Information to be added to Patient Take-Home Summary

Summary and Goals

Summary of Today's Discussion

Summary of Discussion to be added to Patient Take-Home Summary

Reaching the Goal

Prepared By

Pharmacist Full Name (Last Name, First Name)

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

☐ Copy of this record sent to _____

Glossary

* CV= cardiovascular DN- diabetic neuropathy OTC= over-the-counter Rx = prescription BP= blood pressure HbA1C= hemoglobin A1C BMI= body mass index BG = blood glucose FPG= fasting plasma glucose DOB=date of birth GLP-1= Glucagon-like peptide-1 TG=triglyceride DTP = drug therapy problem TC= total cholesterol HDL or LDL= high or low density lipoprotein

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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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Patient's Signature	Pharmacist's Signature