Ontario | Ministry of Health and Long-Term Care

Pharmacists Worksheet

MedsCheck

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

Patient's Home

Lifestyle Information

☐ Tobacco ☐ Yes ☐ No ____ cig/day

☐ Recreational Drug Use ☐ Yes ☐ No ____ Frequency

☐ Alcohol Use ☐ Yes ☐ No ____ Frequency

Smoking Cessation status

Lifestyle Information (notes)

Clinical Need for Service (notes)

Why are you [the pharmacist] conducting this MedsCheck service?

Patient Characteristics / Trigger for Review

- ☐ 3 or more chronic medications
- ☐ Medication regimen that includes one or more non prescription medications
- ☐ Symptoms that seem unaddressed by current pharmacotherapy
- ☐ Multiple prescribers
- ☐ Non-adherence
- ☐ Medication(s) that require routine laboratory monitoring
- ☐ Planned admission to a hospital or other health institution (i.e. long-term care facility)
- ☐ Initiating compliance packaging
- ☐ Known or suspected poor or unstable liver function
- ☐ Multiple acute conditions and/or one or more chronic diseases
- ☐ Medication regimen that includes one or more natural health products
- ☐ Potential drug therapy problem that may be prevented
- ☐ Issues relating to early and/or late refills
- ☐ Patient seems confused about medication regimen
- ☐ Abnormal lab results (blood work, creatinine clearance, etc)
- ☐ Discharge/transition from hospital to community or other healthcare institution
- ☐ Known or suspected poor or unstable renal function
- ☐ Other (Specify)

Sources Consulted to conduct this MedsCheck service

- ☐ Pharmacy Profile — Specify
- ☐ Patient — Specify
- ☐ Another Pharmacy — Specify
- ☐ Laboratory / Test Values — Specify
- ☐ Hospital / Other Facility — Specify
- ☐ Physician / Nurse Practitioner — Specify
- ☐ Caregiver / Agent — Specify
- ☐ Medication Packages — Specify
- ☐ Electronic Health Record — Specify
- ☐ Other (Specify) — Specify

Current Medication List (attach printed records if available. Information to populate MedsCheck Personal Medication Record where appropriate)

Medication 1

Name of Drug/Product (generic/brand)	Strength of Drug/Product	Dosage Form	Rx? OTC? NHP?

Directions for Use	Indication	Adherence Issue Yes / No

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

Medication 2

Name of Drug/Product (generic/brand)	Strength of Drug/Product	Dosage Form	Rx? OTC? NHP?

Directions for Use	Indication	Adherence Issue Yes / No

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

Current Medication List (attach printed records if available. Information to populate MedsCheck Personal Medication Record where appropriate)

Medication 3

Name of Drug/Product (generic/brand)	Strength of Drug/Product	Dosage Form	Rx? OTC? NHP?

Directions for Use	Indication	Adherence Issue Yes / No

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

Medication 4

Name of Drug/Product (generic/brand)	Strength of Drug/Product	Dosage Form	Rx? OTC? NHP?

Directions for Use	Indication	Adherence Issue Yes / No

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

Current Medication List (attach printed records if available. Information to populate MedsCheck Personal Medication Record where appropriate)

Medication 5

Name of Drug/Product (generic/brand)	Strength of Drug/Product	Dosage Form	Rx? OTC? NHP?

Directions for Use	Indication	Adherence Issue Yes / No

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

Medication 6

Name of Drug/Product (generic/brand)	Strength of Drug/Product	Dosage Form	Rx? OTC? NHP?

Directions for Use	Indication	Adherence Issue Yes / No

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

Current Medication List (attach printed records if available. Information to populate MedsCheck Personal Medication Record where appropriate)

Medication 7

Name of Drug/Product (generic/brand)	Strength of Drug/Product	Dosage Form	Rx? OTC? NHP?

Directions for Use	Indication	Adherence Issue Yes / No

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

Medication 8

Name of Drug/Product (generic/brand)	Strength of Drug/Product	Dosage Form	Rx? OTC? NHP?

Directions for Use	Indication	Adherence Issue Yes / No

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)

Medication 1

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

Notes (if applicable)

Medication 2

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

Notes (if applicable)

Medication 3

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

Notes (if applicable)

Medication 4

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

Notes (if applicable)

Medication 5

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

Notes (if applicable)

Medication 6

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

Notes (if applicable)

Therapeutic Issues Identified (if applicable)

Issue 1

Symptom or Condition Not Addressed / Drug Therapy Problem

Therapeutic duplication; drug may not be necessary / Requires drug / Sub-optimal response / Dosage too low or too high / Adverse reaction / Non-adherence / Drug interaction / Other

Suggested Therapy

Action Taken

Notes

Issue 2

Symptom or Condition Not Addressed / Drug Therapy Problem

Therapeutic duplication; drug may not be necessary / Requires drug / Sub-optimal response / Dosage too low or too high / Adverse reaction / Non-adherence / Drug interaction / Other

Suggested Therapy

Action Taken

Notes

Issue 3

Symptom or Condition Not Addressed / Drug Therapy Problem

Therapeutic duplication; drug may not be necessary / Requires drug / Sub-optimal response / Dosage too low or too high / Adverse reaction / Non-adherence / Drug interaction / Other

Suggested Therapy

Action Taken

Notes

Checklist for Completeness

☐ Asked about Rx medications from other individuals, MD samples, pharmacies and care providers	Specify
☐ List of meds removed from home if applicable	Specify
☐ Asked about OTC products purchased or obtained from another individual (including specifically ASA)	Specify
☐ Asked about herbal or natural health products purchased or obtained from another individual	Specify
☐ Prompted for specific dosage, timing and directions for each medication	Specify
☐ Asked about anti-infectives used in the last 3 months	Specify
☐ Referenced attached notes, results, references as appropriate	Specify
☐ Discussed circle of care, sharing information with other providers and patient responsibility for providing accurate information	Specify
☐ Discussed anticipated date of completion of patient's MedsCheck Personal Medication Record	Specify
☐ Ensure clinically relevant information is documented and readily retrievable for continuity of care and audit purposes	Specify
☐ Other (Specify)	Specify

Plan for Follow Up

Healthcare providers with whom to communicate

Health Care Provider 1

Last Name | First Name | 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

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)