DRUG REGIMEN REVIEW

Pharmacy Name: ______________________________ **Phone/Fax:** ______________________

Allergies: **(Mark all that apply)**

❑ **No Known Allergies** ❑ **Drugs:** ____________ ❑ **Chemicals:** ____________

❑ **Animals:** ____________ ❑ **Plants:** ____________ ❑ **Other:** ____________

List all medications patient is presently taking, including oxygen, over the counter, and herbal remedies. Indicate whether medication is new (N), changed (C) and the date.

Medication (as appears on label)	Dose	Amount	Route	Frequency	N/C Date	R/T Terminal Illness	Knowledge Level	Issues
						❑ Yes ❑ No	❑ Understands ❑ Needs teaching	
						❑ Yes ❑ No	❑ Understands ❑ Needs teaching	
						❑ Yes ❑ No	❑ Understands ❑ Needs teaching	
						❑ Yes ❑ No	❑ Understands ❑ Needs teaching	
						❑ Yes ❑ No	❑ Understands ❑ Needs teaching	
						❑ Yes ❑ No	❑ Understands ❑ Needs teaching	
						❑ Yes ❑ No	❑ Understands ❑ Needs teaching	
						❑ Yes ❑ No	❑ Understands ❑ Needs teaching	
						❑ Yes ❑ No	❑ Understands ❑ Needs teaching	
						❑ Yes ❑ No	❑ Understands ❑ Needs teaching	
						❑ Yes ❑ No	❑ Understands ❑ Needs teaching	
						❑ Yes ❑ No	❑ Understands ❑ Needs teaching	
						❑ Yes ❑ No	❑ Understands ❑ Needs teaching	

❑ **See attached computer-generated Medication Profile** ❑ **Note additional meds listed above**

❑ **Drug regimen listed above reviewed for clinically significant medication issues including:**

Ineffective drug therapy: ❑ None noted Comments: ____________

Significant side effects: ❑ None noted Comments: ____________

Significant drug interactions: ❑ None noted Comments: ____________

Significant drug-food interactions: ❑ None noted Comments: ____________

Duplicate drug therapy: ❑ None noted Comments: ____________

Noncompliance, omission, dosage errors: ❑ None noted Comments: ____________

Drug therapy associated with lab testing ❑ None noted Comments: ____________

❑ **Physician notified to resolve clinically significant medication issues/reconciliation:** ____________

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NURSE SIGNATURE: ______________________________ **DATE:** ____________

PATIENT NAME: (Last, First) ______________________________

HOS