CPC Cognitive Pharmacist Consultants

Ph: 0438291664

HOME MEDICINES REVIEW REFERRAL FORM

Provider / Patient details may be completed by the practice staff

COMMUNITY PHARMACY DETAILS:
(nominated by the patient)

Name:

PATIENTS DETAILS:
(or affix label with patient details here)

Name:

Address:

D.O.B:

Medicare No:

DVA No:

Patient/Carer Contact:

GENERAL PRACTITIONER DETAILS:

Name:

Address:

Provider No:

Prescriber No:

Phone:

Fax:

Email:

PREFERRED MEANS OF RECEIVING REPORT:

ISSUES THAT MAY INFLUENCE MEDICATION USE OR EFFECTIVENESS:

- ☐ Vision
- ☐ Hearing
- ☐ Language and/or literacy problems
- ☐ Swallowing
- ☐ Cognition (memory and comprehension)
- ☐ Dexterity (manual coordination)

DOES PATIENT SMOKE?

☐ Yes ☐ No ☐ Ex Smoker

DOES PATIENT DRINK?

☐ Don't drink ☐ Approx ☐ drinks per week

OTHER PATIENT INFORMATION

Height: Cm

Weight: Kg

Blood Pressure:

VACCINATION STATUS (TICK IF UP TO DATE)

- ☐ Influenza
- ☐ Rubella
- ☐ COVID19
- ☐ Hepatitus B
- ☐ Tetanus
- ☐ Other

MEDICATION DOSE ADMINSTRATION

☐ Self ☐ Partner / Carer

AIDS OR OTHER EQUIPMENT USED:

- ☐ Peakflow meter
- ☐ Spacer
- ☐ Nebuliser
- ☐ Blood Glucose Meter
- ☐ Multi/unit dose DAA eg Dosette
- ☐ Other

INDICATION FOR HMR

ALLERGIES OR ADVERSE REACTIONS TO MEDICATION

DRUG	REASON FOR PRESCRIPTION	REACTION

CURRENT CONDITIONS AND MEDICATIONS

CONDITIONS / DIAGNOSIS eg Diabetes	MEDICATION OR OTHER TREATMENT eg Daonil or Diet	STRENGTH, DOSAGE AND FREQUENCY eg 5mg before breakfast	THERAPEUTIC GOALS eg Sugar control	ISSUES eg Visual difficulties

RELEVANT LABORATORY RESULTS AND BLOOD LEVELS (eg serum electrolytes, liver function tests etc. as relevant OR attach any relevant tests)

TEST TYPE	DATE	ISSUES

I HAVE EXPLAINED TO THE PATIENT:

The process involved in having a HMR; and

THE PATIENT UNDERSTANDS THAT:

- The location of the HMR is at their choice, but preferably in their own home; and
- The pharmacist who will conduct the HMR will communicate with me information arising from the HMR; and

THE PATIENT HAS CONSENTED:

- To me releasing to the pharmacist information about their medical history and medications; and

THE PATIENT HAS/HAS NOT CONSENTED:

- To me releasing their Medicare No. or DVA No. to the pharmacist for the pharmacist's payment purposes (the medication review service can still be provided if the patient does not consent to release of Medicare No. or DVA No.)

General Practitioner's Signature

Date:

Once completed, please fax referral to **02 86244779** or email to **cogpharmcon@gmail.com**

ACKNOWLEDGEMENT OF RECEIPT OF REFERRAL

From (CPC administrator)

I have arranged to conduct a HMR for (Patient's name)

Pharmacist conducting interview

Signed

CPC Cognitive Pharmacist Consultants

"Committed to optimising medication related outcomes for people with disability"

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