

RESIDENTIAL MEDICATION MANAGEMENT REVIEW SAMPLE FORM

Use of a specific form to record RMMR is not mandatory but RMMR should cover the matters listed below.

Resident's details: Surname: _____ DOB ___/___/___ Other names: New resident: <input type="checkbox"/> Existing resident: <input type="checkbox"/>	Medicare No. DVA No. Pension No. Next of kin/guardian/carer details: Name: _____ Phone: _____
New resident: Admission date: ___/___/___ Has resident had a CMA? No Yes If yes has relevant information from the CMA been provided to reviewing pharmacist? No Yes	Existing Resident: Previous RMMR: <input type="checkbox"/> No <input type="checkbox"/> Yes if yes, Date of last RMMR: ___/___/___ If less than 12 months, reason for RMMR:
GP name: Phone: _____ Fax: _____ Email: _____ Is this the resident's usual doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reviewing pharmacist name: Phone: _____ Fax: _____ Email: _____ Accredited? <input type="checkbox"/> Yes <input type="checkbox"/> No
Resident consent Pre-review discussion with Patient <input type="checkbox"/> Yes Consent for a RMMR obtained? <input type="checkbox"/> Yes Consent given by <input type="checkbox"/> Resident <input type="checkbox"/> Representative	Advance Care Directive (or similar?) <input type="checkbox"/> No <input type="checkbox"/> Yes Enduring Medical Power of Attorney: <input type="checkbox"/> No <input type="checkbox"/> Yes Power of Attorney details: Name: _____ Phone: _____

CLINICAL INFORMATION RELEVANT TO THE RMMR

Principal diagnoses

Allergies and drug intolerance

OTHER SIGNIFICANT HEALTH PROBLEMS

Resident Smokes: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Ex Smoker Drinks: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Drinks per week Height: Weight: Blood Pressure: Aids or other equipment used:	Issues that may influence medication use or effectiveness: Vision: Language/literacy: Cognition: Hearing: Swallowing Dexterity:
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I confirm that resident has consented to the release of information about their medical history, medications, Medicare and DVA Numbers to the reviewing pharmacist.

GP's Signature: _____ ___/___/___

RESIDENTIAL MEDICATION MANAGEMENT REVIEW SAMPLE FORM

Use of a specific form to record the pharmacist component of RMMR is not mandatory but the pharmacists report should cover the matters listed below.

PHARMACIST COMPONENT OF THE REVIEW

Reviewing Pharmacist Name: Phone: _____ Fax: _____ Email: _____ Accredited: <input type="checkbox"/> Yes <input type="checkbox"/> No	Referring GP Name: Phone: _____ Fax: _____ Email: _____
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PRE-REVIEW DISCUSSION BETWEEN PHARMACIST AND GP

Has a pre-review discussion between the GP and pharmacist taken place? Yes No

RESIDENT'S MEDICATIONS

Prescribed Medication

Non-prescribed Medication

IDENTIFIED PROBLEMS/ISSUES

Issue	Suggested action

ANY OTHER ISSUES

I confirm that I have reviewed Mr/Mrs/Miss/Ms _____ and that I forwarded a report outlining the outcomes of the review to Dr _____ on ____/____/____
 Reviewing Pharmacist's Signature: _____ / /

