PRACTICE PHARMACIST RECORD FORM – INITIAL CONSULTATION

Date: 
Practice: 
Patient ID: 
Time started consultation: 
Time finished consultation: 

Where was the consultation?
- Medical centre
- Participant’s home
- Residential Aged Care Facility?

Did the consultation occur within five days after hospital discharge?
- Yes
- No
  Why?:____________________________________________________________

Do you have access to the participant’s medication discharge summary?
- Yes
- No

Did the participant register for a My Health Record?
- Yes
- No

1. MEDICATION RECONCILIATION

What sources did you use?
- Participant recall
- Participant’s medication label
- Medication discharge summary
- Medical records at the practice
- Community pharmacy dispensing history
- Other:____________________________________________________________

How many changes were made in hospital?

____________________
Did you update participant’s records in medical centre?

☐ Yes
☐ No: ________________________________

Did you forward an updated medication list to the participant’s community pharmacy?

☐ Yes
☐ No: ________________________________

What were the changes?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Did you discuss changes made in hospital with the patient?

☐ Yes
☐ No: ________________________________

2. HOSPITAL TREATMENT PLAN

Was there a hospital treatment plan?

☐ Yes
☐ No

Is the plan appropriate?

☐ Yes
☐ No
☐ Cannot determine: ________________________________

Did you discuss hospital treatment plan with the patient?

☐ Yes
☐ No: ________________________________
3. MEDICATION REVIEW

Using the DOCUMENT classification system, please identify any drug related problems:

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<th>DOCUMENT Code</th>
<th>Drug(s) involved</th>
<th>Comments</th>
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Any other comments:

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Using the DOCUMENT classification system, please record your recommendations:

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Any other comments:
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Were these all communicated to the participant’s GP?

☐ Yes

☐ No
   Why not? ________________________________________________________________
4. COMMUNICATION
Who did you contact to discuss the participant’s care?

☐ None
☐ GP
Was this written, verbal or both? ________________________________

☐ Community pharmacy
Reason (e.g. referral of services, follow up):________________________

☐ Hospital
Reason (e.g. clarification):_________________________________________

☐ Carer
☐ Specialist: ____________________________
☐ Other: ____________________________________________

When discussing the case with the GP, was this written, verbal or both?

☐ Written
☐ Verbal
☐ Both

CASE COMMENTS:
PRACTICE PHARMACIST RECORD FORM –FOLLOW UP

Date:
Practice:
Patient ID:
Time started consultation:
Time finished consultation:

FOLLOWING UP AFTER GP CONSULTATION
Did the GP make any changes to the patient’s medication regimen?

☐ Yes
☐ No (why):

What actions were undertaken by the GP following the pharmacist consultation?

☐ Referrals:________________________________________
☐ Pathology:________________________________________
☐ Other:______________________________________________

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

How did you follow up with the participant?

☐ Consultation in the medical centre
☐ Consultation in the participant’s home
☐ Consultation in RACF
☐ Via telephone
☐ Other:_____________________________________________________

1. MEDICATION RECONCILIATION

Has there been any changes since the initial consultation?

☐ Yes
☐ No
If **YES**, did you update record in medical centre?

- □ Yes
- □ No: ________________________________________________

What were the changes?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Did you discuss changes with the patient?

- □ Yes
- □ No: ________________________________________________

2. HOSPITAL TREATMENT PLAN

Has the hospital treatment plan been implemented?

- □ Fully implemented
- □ Partially implemented
- □ Not implemented

3. BRIEF MEDICATION REVIEW

Using the DOCUMENT classification system, please identify any **new** drug related problems:

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Any other comments:
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4. COMMUNICATION

Who did you contact to discuss the participant’s care?

☐ None

☐ GP
Was this written, verbal or both? ________________________________

☐ Community pharmacy
Reason (e.g. referral of services, follow up): ________________________________

☐ Hospital

Were these all communicated to the participant’s GP?

☐ Yes

☐ No
Why not? ________________________________

Any other comments:
___________________________________________________________________________
___________________________________________________________________________

___________________________________________________________________________

_________________________________________
Reason (e.g. clarification): ______________________________________________________

☐ Carer

☐ Specialist: _________________________________________________________________

Other: ________________________________________________________________

Do you intend to follow up with the participant again?

☐ Yes
  When? _________________________________________________________________
  Why?
  _________________________________________________________________
  _________________________________________________________________
  _________

☐ No
PRACTICE PHARMACIST RECORD FORM –RECORDING OUTCOMES OF FOLLOW UP

Date:
Practice:
Patient ID :
Time started:
Time finished:

What occurred as a result of your follow up?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
PRACTICE PHARMACIST RECORD FORM – OTHER ACTIVITIES

Date: __________________________
Practice: _______________________
Time started: __________________
Time finished: __________________

Please describe any activities undertaken at the medical centre that were not directly related to a participant’s care.

☐ Education
☐ Provide advice on therapeutic management for a particular patient
☐ Contact with community pharmacy
☐ Refer patients for professional services undertaken by the community pharmacy such as Home Medicine Reviews, MedsCheck or blood pressure monitoring.
☐ Informal discussions with GP
☐ Informal discussions with other allied health professionals (e.g., nurse, physiotherapist, dietician)
☐ Attended meetings
☐ Other:

________________________________________________________________________
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