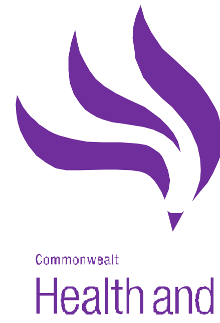
DOMICILIARY MEDICATION MANAGEMENT - HOME MEDICINES REVIEW: MEDICATION MANAGEMENT PLAN



DOMICILIARY MEDICATION MANAGEMENT - HOME MEDICINES REVIEW: MEDICATION MANAGEMENT PLAN

GENERAL PRACTITIONER DETAILS:

Name: ....

Address:..

....

....

Provider Number: ....

Prescriber No:...

Phone: ....

Fax: ....

Email:...

PATIENT DETAILS:

Name: ....

Address:..

....

....

Medicare No: ....

DVA No:...

Patient/carer contact: ....

COMMUNITY PHARMACY:

Name: ....

Address: ....

....

....

Phone: ....

Fax: ....

Email:...

ACCREDITED PHARMACIST (If different)

Name: ....

Date of Pharmacist Review..

Date of follow-up consultation ....

CURRENT CONDITION/PROBLEM	CURRENT MANAGEMENT*	PROPOSED PLAN OF ACTION	PERSON RESPONSIBLE FOR ACTION**	EXPECTED OUTCOMES	PATIENT AGREES
		☐ No action required ☐ Action (comment):			
		☐ No action required ☐ Action (comment):			
		☐ No action required ☐ Action (comment):			
		☐ No action required ☐ Action (comment):			
		☐ No action required ☐ Action (comment):			
		☐ No action required ☐ Action (comment):			

*pharmacological and/or non-pharmacological

** nominate other health care professional if applicable

General Practitioner ....

Patient ....

Date................................

Attach addtional information if necessary.

Additional forms are available through Leigh Mardon: 1800 067 307. Please quote form # 2970.

Copy for patient's records

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Name: ....
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Provider Number: ....
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Fax: ....
Email:..

PATIENT DETAILS:

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Medicare No: ....
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Patient/carer contact: ....

COMMUNITY PHARMACY:

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Fax: ....
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*pharmacological and/or non-pharmacological

** nominate other health care professional if applicable

General Practitioner .... Patient .... Date...............................

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Copy to be offered to patient

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Name: ....

Address:..

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Prescriber No:..

Phone: ....

Fax: ....

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Date of Pharmacist Review...

PATIENT DETAILS:

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Address: ....

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Medicare No: ....

DVA No:...

Patient/carer contact: ....

Date of follow-up consultation ....

COMMUNITY PHARMACY:

Name: ....

Address: ....

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Fax: ....

Email:..

ACCREDITED PHARMACIST (If different)

Name: ....

CURRENT CONDITION/PROBLEM	CURRENT MANAGEMENT*	PROPOSED PLAN OF ACTION	PERSON RESPONSIBLE FOR ACTION**	EXPECTED OUTCOMES	PATIENT AGREES
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Copy for community pharmacist