Medication Review Form

Facility nurse to complete form within one week prior to scheduled medication review. All information will contribute to a bi-annual meaningful medication review with facility staff, pharmacist, and physician.

Completed by: _____ Job title: _____ Date: _____

RESIDENT INFORMATION			
Last name:	First name:	DOB:	
BP range over last 6 months:			Crushed meds: Yes / No
No. of regular meds:	No. of PRNs:	Admission weight:	Current weight:
Relevant lab results:	Drug allergies:		

Please check all issues that apply and provide a detailed description of concerns

	ISSUE	DESCRIPTION
❒	Resident refuses medication	*Which ones, how often and why?*
❒	Resident experiences shortness of breath	
❒	Resident has problems using inhalers	
❒	Resident has edema	*Location and severity.*
❒	Resident has pain	*Describe pain. Which PRNs are being used? Are they effective?*
❒	Resident has behavioural issues	*If yes, please attach additional information/observation sheet.*
❒	Resident has sleep issues	*Describe.*
❒	Resident has bowel issues	*Medication effective?*
❒	Wounds / skin issues	*Location and reason.*
❒	Resident has change in appetite/digestive issues	*Describe.*
❒	Resident has history of falls	*Fall risk: Low/medium/high (please check)* *Date of last fall:* *Details:*
❒	Other medication-related concerns	