This form must remain with the current medication chart/s during admission **Form** _____ **of** _____

SITE _____

MEDICATION HISTORY AND MANAGEMENT PLAN

WARD _____ TEAM _____

Affix patient identification label here and overleaf

UMRN:
Family Name:
Given Name(s):
Address:

DOB:

AFFIX LABEL HERE

SEX ☐ M ☐ F

ALLERGIES & ADVERSE DRUG REACTIONS (tick appropriate box)
☐ Nil Known ☐ Unknown ☐ Reaction – refer to HMC

1st user to print patient name and check label correct:

Identified Medication Management Issues

Date / Time	Issue Identified and Proposed Action	Person Responsible	Result of Action
	Issue identified by: Contact number:	Contacted Y / N	Date / Time:
	Issue identified by: Contact number:	Contacted Y / N	Date / Time:
	Issue identified by: Contact number:	Contacted Y / N	Date / Time:

Medication Status Legend Reconciled with HMC and Discharge Plan columns
NEW: New medication √ : Continued Δ : Changed X: Ceased
W: Withheld ↑: Increased dose ↓: Decreased dose ☐: Not charted

Checklist: ☐ Dose administration aid:_____
☐ Oral medications/liquids ☐ Inhalers ☐ Topical
☐ Eye/Ear/Nose ☐ Injections ☐ OTC ☐ Complementary

Recent Medication Changes in the Past 4 weeks (including reason for change and by whom)

Medication History – Medications Taken Prior to Admission ☐ Nil Regular Medications

Medication Generic Name / Trade Name, Strength and Form (i.e. SR, wafers etc.)	Dose, Frequency & Route	Reconciled with HMC at admission	Comments	Discharge Plan (Refer to Legend)

Admission Date:___/___/___ Time:___:___
Date/Time Completed:___/___/___ ___:___ Name:_____ Page:_____ ☐ Doctor ☐ Pharmacist ☐ Nurse/Midwife

MR000 MEDICATION HISTORY AND MANAGEMENT PLAN

VERSION 4
xxx
11/21

Abbreviation Key

GP – General Practitioner CP – Community Pharmacist
CF – Care Facility CMI – Consumer Medicines Information
D/C – Discharge ADR – Adverse Drug Reaction
T/F – Transfer POM – Patient's Own Medications

UMRN:
Family Name:
Given Name(s):
Address:

DOB:

AFFIX LABEL HERE

SEX ☐ M ☐ F

Patient Presentation

Presenting Complaint_____
Past Medical History_____
_____
_____
_____

Current smoker: ☐ Yes ☐ No NRT offered: ☐ Yes ☐ No ☐ Declined
☐ Recreational substances ☐ Alcohol intake

Date_____
Wt_____kg
IBW_____kg
Ht_____cm
BMI____kg/m²
BSA_____m²

RENAL FUNCTION ON ADMISSION

Date	SCr	CrCl

OTHER TEST RESULTS

Pre-Admission Medication History Has Been Confirmed with Two Sources

(☐ Nil Regular Medications ☐ Second Source deemed unnecessary Sign_____)

	Sign		Sign		Sign
☐ CP Ph: Fax: Email:		☐ Patient ☐ Relative ☐ Carer Name if not patient _____		☐ Own Medications ☐ POM S8/S4R ☐ POM Fridge Consent to use ☐	
☐ CF Ph: Fax: Email:		☐ Outpatient Clinic Notes Location:_____ Date:___/___/____		☐ Patient's own medication list Date updated:___/___/___	
		☐ Previous admission at:_____ Hospital: Date of D/C / T/F:___/___/___		☐ My Health Record	
☐ GP Ph: Fax: Email: ☐ GP letter/medication list Date:___/___/___		Dose Administration Aid (D.A.A.) ☐ Nil ☐ Blister Pack ☐ Sachet ☐ Dosette ☐ Other:_____ Date Packed:___/___/___		☐ Other (specify):	

Medication Risk Assessment on Admission

Can open bottles/measure liquid: ☐ Yes ☐ No	Can understand English: ☐ Yes ☐ No
Compliance with medications: ☐ Yes ☐ No ☐ Unclear	Can read: ☐ Yes ☐ No
Medications managed by:	Can see/read labels: ☐ Yes ☐ No

Swallowing Status on Admission

☐ Nasogastric Tube ☐ PEG/RIG	Oral liquid preferred: ☐ Yes ☐ No
Thickened Fluids ☐ Level 2 ☐ Level 3 ☐ Level 4	Crushing required: ☐ Yes ☐ No

Discharge and Transfer Medication Plan

Education Provided to Patient

☐ Interpreter required ☐ ADR Brochure
☐ Medicine information leaflet:_____
☐ CMI:_____
☐ Verbal counselling to patient / carer ☐ Not required / declined
☐ Medication list provided on discharge

Community Liaison

☐ Patient denied consent to contact GP/CP
☐ Copy of medication list faxed to GP/Clinic
☐ Liaison with CF regarding D/C medications
☐ Medication list/prescription faxed/emailed to CP
☐ Fax front of WA Anticoagulation Chart to GP

Medication Reconciliation at Discharge

☐ Discharge medications reconciled with medications prescribed at discharge on HMC
☐ Pharmacist involvement in discharge summary

Patient's Medications at Discharge

☐ Patient's Own Medications reviewed
☐ Patient's Own S8, S4R and Fridge items reviewed
☐ Dose Administration Aid required - Packed by:_____

Medications at Discharge

☐ Nil Medications required ☐ Dispensed at hospital ☐ Prescription given to patient ☐ Prescription posted to CP

Pharmacist Comments and Medication Issues

_____
_____
_____
_____
_____

☐ Discharge reconciliation ☐ Medication plan ☐ Medication list
Date/Time Completed:___/___/___ ___:___ Name:_____ Page:_____ ☐ Doctor ☐ Pharmacist ☐ Nurse/Midwife

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