**[Facility Name]: Medication Review Preparation Form**

To be completed by the Resident’s Nurse and Pharmacist

**Purpose:** Medication reviews are done bi-annually, as part of the Best Practice Expectations. This form is to be completed by the LPN/RN and Pharmacist prior to discussion with the Physician, when it will then be reviewed, ideally as an interdisciplinary team, as a way to ensure quality care is provided.

**Scheduled Review Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last MRP Visit Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NURSE TO COMPLETE:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| **VITAL SIGNS** | **LATEST VALUE** | | **PREVIOUS VALUE** | |
| --- | --- | --- | --- | --- |
| **Value** | **Date** | **Value** | **Date** |
| **Blood Pressure (mmHg)** |  |  |  |  |
| **Pulse** |  |  |  |  |
| **Weight (kg)** |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **RESIDENT STATUS** |  | **COMMENTS** |
| **GENERAL** | **Are there any recent marked changes to the resident’s**  **health status?** | ☐ Yes  ☐ No | **Specify:** |
| **MENTAL WELL-BEING** | **Has a Geriatric Psychiatrist**  **seen in the last 6 months?** | ☐ Yes  ☐ No | **Date:** |
| **Sleep concerns?** | ☐ Yes  ☐ No | **Any Responsive Behaviours?** |
| **Mental Health/Mood concerns?** | ☐ Yes  ☐ No | **Any Responsive Behaviours?** |
| **MOBILITY** | **Fall Risk** | ☐ Yes  ☐ No | **Reason:** |
| **Date of Last Fall:** |
| **Number of falls in last 6 months:**  (or since last review) |

|  |  |  |  |
| --- | --- | --- | --- |
| **MOBILITY** | **Able to walk?** | ☐ Yes  ☐ No | **Independently or with assistance?** ☐ Independent ☐ Assisted |
| **Able to stand?** | ☐ Yes  ☐ No | **Independently or with assistance?** ☐ Independent ☐ Assisted |
| **MEDICATIONS** | **Are medications taken whole or crushed?** | | ☐ Whole ☐ Crushed |
| **Are they having to take crushed medications as a result of compromised swallowing?** | ☐ Yes  ☐ No | **All or specific medications?** |
| **How often?** |
| **What is usually done?** |
| **Are they refusing to take oral medications?** | ☐ Yes  ☐ No | **Reasons:** |
| **Any nursing concerns about medications?** | ☐ Yes  ☐ No |  |
| **PRN** | **Any PRN’s that are being used frequently that could be ordered regularly?** | ☐ Yes  ☐ No |  |
| **Any PRN’s that have not been used in the last 60 days? Specify** | ☐ Yes  ☐ No |  |

**PHARMACIST TO COMPLETE:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  | **RESIDENT STATUS** |  | **COMMENTS** |
| **MEDICATIONS** | Are all medications indicated (ie. Matching diagnosis?) | ☐ Yes  ☐ No |  |
| Does the Resident have a condition that is not being treated? | ☐ Yes  ☐ No |  |
| Are there any medications that could be contributing to falls? | ☐ Yes  ☐ No |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **LABORATORY VALUES** | **LATEST VALUE** | | **PREVIOUS VALUE** (as needed) | |
| **Value** | **Date** | **Value** | **Date** |
| **Ferritin** (20 – 160 ug/L) |  |  |  |  |
| **Hemoglobin** F (120-150g/L); M (136-170 g/L) |  |  |  |  |
| **HCT** (0.35-0.45L/L) |  |  |  |  |
| **MCV - Mean Cell Volume** (82 – 98 fL) |  |  |  |  |
| **B12 - Vitamin B12** (150 – 600 pml/L) |  |  |  |  |
| **Na+ - Sodium** (135 – 145 mmol/L) |  |  |  |  |
| **K+ - Potassium** (3.5 – 5.0 mmol/L) |  |  |  |  |
| **eGFR – Estimated Glomerular Filtration Rate** (ml/min) |  |  |  |  |
| **SCr - Serum Creatinine** (60 – 100 umol/L) |  |  |  |  |
| **HgA1c – Average Blood Glucose Levels** (%)  On Diabetic Medications: Yes ☐ No ☐ |  |  |  |  |
| **INR - International Normalized Ratio** |  |  |  |  |
| **TSH** (0.34 – 5.6 mlU/L)  On Thyroid Medications: Yes ☐ No ☐ |  |  |  |  |
| **Liver Function Tests** |  |  |  |  |
| **Other Applicable Lab Values:** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Medical Coordinator:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Comments:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_