

Explanatory Notes

Completing Medication History Form

PATIENT IDENTIFICATION

The medication history form should have EITHER the current patient identification label OR, as a minimum, the patient name, UMRN, date of birth and gender written in legible print.

CHECKLIST

This check should be used to ensure a COMPLETE medication history is recorded. It includes a number of items that are often omitted. When a complete medication history has been taken all the boxes should be ticked.

RECORDING MEDICATION HISTORY

The medication history comprises:

- A list of all current medicines including:
 - all current prescription medications for all routes of delivery,
 - non-prescription medicines, including over the counter(OTC) drugs, other medicines available from retail pharmacies and supermarkets,
 - complementary health care products, and
 - medicines used intermittently.
- Recent changes to the medication list.
- Past history of adverse drug reactions (ADRs) including allergies.
- Other (recreational) drug use.
- The person recording the history and the source of the information.

Name, signature and date

The person initially recording the medication history should print and sign their name and record the date that the medication history was recorded.

Current medications

The medicine (generic name, brand name, strength and form)

Each medicine that patient is taking should be clearly identified using the generic name (active ingredient), the brand name, the strength and dose form. In the case of some complementary medicines the active ingredient/strength may be unknown.

The dosing regimen (dose, frequency and route)

The patient's dosing regimen including the dose, the frequency and route should be clearly described. Abbreviations for recording this information should comply with the Guidelines for completing the national in patient medication chart (NIMC).

Indication

This is the indication as reported by the patient/carer or other source of the medication history.

Comments

Relevant comments should be recorded here including:

- start time/duration if relevant, and
- an assessment of poor compliance.

Plan

The doctor responsible for the patient's ongoing treatment should indicate the plan for each of the current medications recorded. Drugs added to the treatment regimen do not appear on this form which is restricted to the list of medicines the patient was using prior to hospitalisation. This plan will be used by the person reconciling the medication history with the medication chart to check for unintended discrepancies.

M- Maintain at the same dosing regimen
C- Cease the drug

W- Temporarily withhold the drug
Δ- Change dosing regimen or change drug.

List of current medications continues over the page

Where the current medications exceed 12, remaining medications can be listed on the reverse side of the form. In this case the box should be ticked to indicate there are more drugs listed over the page.

Recently ceased or changed drugs

Any changes to the medication regimen within the past month (or as appropriate) should be recorded here. This may include a drug stopped; a drug changed eg "metoprolol twice daily, changed to atenolol once daily two weeks ago"; or a change in the dose.

Past ADRs including allergies

Record the **drug** involved, the **nature** and **severity** of the event. Record the approximate date. This can be recorded as either month and year or just year as appropriate/known. If the approximate date is unknown include more general time eg 20 years ago.

Other drugs

Record the use of recreational drugs including tobacco and alcohol as well as illicit drugs.

Source

The person initially recording the medication history should indicate the source of the information by sequentially numbering the sources used.

Where the medication history is confirmed using other sources then these should also be indicated by sequentially numbering the sources used.

Patients own medicines	Packets, bottles etc bought in from home. Where possible, these should be used in conjunction with interview.
Patients medication list	Written list of medications provided by patient (any origin)
Patient/carer/family interview	Verbal report of treatment regimen.
Webster pack	Patient's Webster pack bought in from home.
General practitioner	Direct telephone or fax contact with GP.
Community pharmacist	Direct telephone or fax contact with community pharmacist.
Nursing home	Direct telephone or fax contact with nursing home.
Community nurse	Direct telephone or fax contact with community nurse.
Previous admission	Indicate the date of previous admission.

CONFIRMING MEDICATION HISTORY

The medication history as initially recorded should be confirmed with the patient and where required another source.

Where the medication history is confirmed using other sources then these should be indicated under "Source" by sequential numbering.

Name, signature and date

The person confirming the medication history should print and sign their name and record the date that the medication history was confirmed.

RECONCILING CHART WITH MEDICATION HISTORY

Chart reconciled

Each box should be ticked to indicate that the medication chart reflects the medication history on admission together with the ongoing treatment plan. Any discrepancy should be checked with the responsible medical officer.

Name, signature and date

The person reconciling the medication chart with medication history should print and sign their name and record the date that the medication history was reconciled.

ANCILLARY INFORMATION

This information on the reverse side of the medication history form should be completed to assist the medication management process.

Medication management at home

Usual prescriber

This information may be used to contact the usual prescriber if confirmation of the medication history is required.

Usual community pharmacist

This information may be used to contact the usual community pharmacist if confirmation of the medication history is required.

Level of independence with medicines

Indicate whether the patient self-administers medications at home or, indicate who is responsible for administering medications.

Use of administration aid

Indicate whether the patient uses a medication administration aid and if so, specify the type eg Dosette box, Webster Pak.

Supplementary notes

Detail other relevant information.

Management of Patient's Own Medicines (POM) during hospital stay

This section serves as a check that the POM have been handled appropriately.

Written medication list available

Indicate if a printed medication list is available. If there is a list indicate whether the list has been filed in the medical record.

POM bought to hospital

Medicines placed in POM bag
Medicines transferred with patient

Special notes about patient's medicines

FORM NUMBER

Where the total number of current medications exceed the space available a second Medication History form should be used to complete the list. Indicate the use of additional pages by circling as appropriate.