

CHECKLIST: Ask the patient about the following : (✓)

- prescription medicines
- over the counter medicines
- complementary and alternative medicines including vitamins and nutritional supplements
- topical preparations (patches, creams, ointments, etc)
- eye, ear, nose and throat drops/medications
- inhaled medications
- injections, implants, pessaries, suppositories
- sleeping tablets
- oral contraceptives, hormone replacement therapy
- GI drugs (reflux, heartburn, constipation, diarrhoea)
- analgesics
- other peoples tablets
- social and recreational drugs

Health Service Logo

Hospital: _____

Ward/Unit: _____

AFFIX PATIENT IDENTIFICATION LABEL HERE & OVERLEAF

UR No:

Family Name:

Given Names:

Address:

DOB:

Sex M F

Name and signature of person recording the history

Date recorded

Plan: **M** Maintain, **C** Cease, **W** Withhold, **Δ** Change

Current medicine on admission (generic name, brand name strength and form)	Dose, frequency and route	Indication	Comments eg duration, compliance	Plan	Pharmacy use
				M C W Δ	Chart reconciled ✓ <input type="checkbox"/>
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Current medicines on admission continue over the page (tick if applicable)

Medicines ceased or changed within the last month (or NIL)

ADR/allergies (Include the drug and the nature and severity of the adverse event, and year if known).

Other drugs (recreational etc)

Source - Number in order of use (1,2,3...)

- Patients own medicines
- Webster pack
- Nursing home
- Other - specify
- Patient medication list
- General practitioner
- Community nurse
- Previous admission - specify
- Patient/carer/family interview
- Community pharmacist

Name and signature of person confirming history

Date confirmation completed

Name and signature of person reconciling chart with medication history

Date reconciliation completed

AFFIX PATIENT IDENTIFICATION LABEL HERE & OVERLEAF

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Ancillary Information for Medication Management
Nursing and Pharmacy Use

Usual prescriber GP Hospital doctor (specify) Other (specify)

Usual community pharmacist _____

Level of independence with medicines: Self Family Carer Nursing home

Uses administration aid No Yes (specify)

Supplementary notes

Written medication list available NO YES If YES, list filed in medical record NO YES

Patient's medicines bought to hospital NO YES If YES, medicines in green POM bag NO YES

Medicines transferred with patient NO YES
(specify)

Special notes about patient's medicines

Current medicine on admission (generic name, brand name strength and form)	Dose, frequency and route	Indication	Comments eg duration, compliance	Plan M C W Δ	Pharmacy use Chart reconciled ✓
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