HOME MEDICINES REVIEW - REFERRAL FORM

Provider/Patient details may be completed by the practice staff

COMMUNITY PHARMACY DETAILS:
(nominated by the patient)

Name: ....

PATIENT DETAILS:
(or affix label with patient details here)

Name: ....
Address: ....
....
....
D.O.B: ....
Medicare No: ....
DVA No: ....
Patient/Carer contact: ....

GENERAL PRACTITIONER DETAILS:

Name: ....
Address: ....
....
....
Provider No: ....
Prescriber No: ....
Phone: ....
Fax: ....
Email: ....

PREFERRED MEANS OF RECEIVING REPORT:

....

ISSUES THAT MAY INFLUENCE MEDICATION USE OR EFFECTIVENESS:

- ☐ Vision
- ☐ Hearing
- ☐ Language and/or literacy problems
- ☐ Swallowing
- ☐ Cognition (member and comprehension)
- ☐ Dexterity (eg manual coordination)

DOES PATIENT SMOKE?

☐ Yes ☐ No ☐ Ex smoker

DOES PATIENT DRINK?

☐ Don't drink ☐ approx .... drinks per week

MEDICATION DOSE ADMINISTRATION

☐ Self ☐ Partner/Carer

OTHER PATIENT INFORMATION:

Height: .... Cm
Weight: .... Kg
Blood Pressure: ....

VACCINATION STATUS (TICK IF UP-TO-DATE)

- ☐ Tetanus
- ☐ Rubella
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Influenza
- ☐ Other

AIDS OR OTHER EQUIPMENT USED:

- ☐ Peakflow meter
- ☐ Spacer
- ☐ Nebuliser
- ☐ Blood Glucose Meter
- ☐ Multi/unit dose DAA eg Dosette
- ☐ Other ....

INDICATION FOR HMR

....
....

ALLERGIES OR ADVERSE REACTIONS TO MEDICATION

DRUG	REASON FOR PRESCRIPTION	REACTION

CURRENT CONDITIONS AND MEDICATIONS

CONDITIONS/ DIAGNOSIS eg Diabetes	MEDICATION OR OTHER TREATMENT eg Daonil or Diet	STRENGTH, DOSAGE AND FREQUENCY Eg 5mg before breakfast	THERAPEUTIC GOALS eg Sugar control	ISSUES eg Visual problems

RELEVANT LABORATORY RESULTS AND BLOOD LEVELS (eg serum electrolytes, liver function tests etc. as relevant)

TEST TYPE	DATE	ISSUES

I HAVE EXPLAINED TO THE PATIENT:

- The process involved in having a HMR; and

THE PATIENT UNDERSTANDS THAT:

- The location of the HMR is at their choice, but preferably in their own home; and
- The pharmacist who will conduct the HMR will communicate with me information arising from the HMR; and

THE PATIENT HAS CONSENTED:

- To me releasing to the pharmacist information about their medical history and medications; and

THE PATIENT HAS/HAS NOT CONSENTED:

- To me releasing their Medicare No. or DVA No. to the pharmacist for the pharmacist's payment purposes.*

Date ………………………………..

General Practitioner's Signature …………………………..

* If the patient does not agree to releasing their Medicare No., the HMR service can still be provided.

ACKNOWLEDGEMENT OF RECEIPT OF REFERRAL

From (community pharmacy) ……………………………………………………………………………………………………….

I have arranged to conduct a HMR for ………………………………………………… (Patient's name) on ……………………

Pharmacist conducting interview ……………………………………………………………………………………………..

Signed ………………………………………………………………………………………………