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

SITE _____

MEDICATION HISTORY AND MANAGEMENT PLAN

WARD _____ TEAM _____

SURNAME	URN
GIVEN NAMES	
D.O.B.	SEX

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

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:
	Issue identified by: Contact number:	Contacted Y / N	Date:
	Issue identified by: Contact number:	Contacted Y / N	Date:

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

Checklist:
☐ Oral medications/liquids ☐ Inhalers ☐ Topical
☐ Eye/Ear/Nose ☐ Injections ☐ OTC ☐ Complementary

Recent Medication Changes in the Past 4 weeks	Reason for change	By Whom

Medication History – Medications Taken Prior to Admission ☐ Nil Regular Medications (confirmed by_____)

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

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

MR000 MEDICATION HISTORY AND MANAGEMENT PLAN

xxx
03/17
VERSION 3

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

SURNAME	URN
GIVEN NAMES	
D.O.B.	SEX

Patient Presentation

Presenting Complaint_____

Past Medical History_____

_____

_____

_____

Wt_____kg

IBW_____kg

Ht_____cm

BSA_____m^2

RENAL FUNCTION ON ADMISSION	
Date	
Serum Creatinine (micromol/L)	
Cr Cl (mL/min)	

Pre-Admission Medication History Has Been Confirmed with Two Sources

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

	Sign		Sign		Sign
☐ CP Ph: Fax:		☐ Patient ☐ Relative ☐ Carer Name if not patient _____		☐ Own Medications ☐ POM S8/S4R ☐ POM Fridge	
☐ CF Ph:		☐ Previous admission at: _____ Hospital: Date of D/C / T/F: ___/___/___		☐ Patient List	
☐ GP Ph: Fax: ☐ GP letter Date: / /		Dose Administration Aid (D.A.A.) ☐ Nil ☐ Blister Pack ☐ Sachet ☐ Dosette ☐ Other:_____ Date Packed:_____/_____/_____		☐ Other:	

Medication Risk Assessment on Admission

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

Swallowing Status on Admission

☐ Nasogastric Tube ☐ PEG ☐ Gastrostomy	Oral liquid preferred: ☐ Yes ☐ No
Thickened Fluids ☐ L150 ☐ L400 ☐ L900	Crushing required: ☐ Yes ☐ No

Discharge and Transfer Medication Plan

Education Provided to Patient
- ☐ Interpreter required
- ☐ ADR Brochure
- ☐ Patient information leaflet
- ☐ Consumer Medicine Information (CMI)
- ☐ Verbal counselling to patient / carer
- ☐ Medication list provided on discharge

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

Medication Reconciliation at Discharge
- ☐ Discharge medications reconciled with medications prescribed at discharge on NIMC
- ☐ 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

Pharmacist Comments and Medication Issues

_____

_____

_____

_____

_____

_____

_____

☐ Discharge reconciliation ☐ Medication plan ☐ Medication list

Date/Time Completed:___/___/____ ___:___ Name_____ Page:_____ ☐ Doctor ☐ Pharmacist ☐ Nurse

Version 3 2017. Developed by the WA Medication Safety Network together with the Office of Safety and Quality WA. WA Health acknowledges contributions from the Alfred Hospital, The Queen Elizabeth Hospital, Queensland Health Medication Management Services and Armadale Kelmscott Memorial Hospital.