(Affix patient identification label here and overleaf)

Medication Management Plan

URN:
Family name:
Given names:
Address:

Date of birth: Sex: ☐ M ☐ F

1st Clinician to Print Patient Name and Check Label Correct:.....

MEDICATION CHANGES DURING ADMISSION

COMMENTS (e.g. medication administration, liaison required, supply notes)

MEDICATION DISCHARGE CHECKLIST

- ☐ Reconciled on discharge Sign: ..... Date: .....
- ☐ Own medicines returned Sign: ..... Date: .....
- ☐ Permission for disposal of medicines Sign: ..... Date: .....
- ☐ Medication supply Sign: ..... Date: .....
- ☐ Dose administration aid Type: .....
- ☐ Script given to patient (if applicable)
- ☐ Discharge Medication Record given/sent to: ☐ Patient ☐ GP ☐ Pharmacy ☐ Other: .....
  Sign: ..... Date: .....
- ☐ Consumer Medicine Information Sign: ..... Date: .....
- ☐ Education provided Sign: ..... Date: .....
- ☐ Recommend Home Medicines Review referral (see checklist below)? ☐ Yes ☐ No

RECOMMENDING A HOME MEDICINES REVIEW REFERRAL CHECKLIST

Consider recommending a Home Medicines Review referral because:

- ☐ Difficulty managing medicines
- ☐ Suspected non compliance
- ☐ Inability to manage drug related therapeutic devices
- ☐ Taking more than 5 medicines
- ☐ Taking more than 12 doses per day
- ☐ Significant changes to medication regimen during admission
- ☐ Medication requiring therapeutic monitoring
- ☐ Other: .....

KEEP WITH ACTIVE MEDICATION CHART - DO NOT REMOVE

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

CUT THIS OFF

Date of admission: d d / m m / y y y y

Medication Management Plan

Ward / Clinic:

Facility/Service:

Consultant:

Date / Time	Issue Identified	Proposed Action	Person Responsible	Date of Action	Result of Action
		Issue identified by: Contact number:			
		Issue identified by: Contact number:			
		Issue identified by: Contact number:			
		Issue identified by: Contact number:			
		Issue identified by: Contact number:			
		Issue identified by: Contact number:			
		Issue identified by: Contact number:			
		Issue identified by: Contact number:			

MEDICATION MANAGEMENT PLAN

National Medication Management Plan 07/2010 v0.06 – © Commonwealth of Australia 2010 – The ACSQHC acknowledges the significant contribution of Queensland Health

KEEP WITH ACTIVE MEDICATION CHART - DO NOT REMOVE

Please see over

CUT THIS OFF

RECENTLY CEASED OR RECENT CHANGES TO MEDICINES *(prior to presentation to hospital)*

SOURCES OF MEDICINE LIST

Source	Confirmed by	Date	Source	Confirmed by	Date
☐ General Practitioner			☐ Own Medicines		
☐ Community Pharmacist			☐ Community Nurse		
☐ Patient / Carer			☐ Patient List		
☐ Nursing Home			☐ Previous Admission		

GENERAL INFORMATION

Medicines usually administered by: ☐ Self ☐ Other (if other, specify):

Preferred administration method:

Did patient bring own medicines? ☐ Yes ☐ No Location of own medicines:

Patient's immunisation up to date? ☐ Yes ☐ No

General Practitioner details	Community Pharmacist details	Residential Care Facility details

MEDICATION RISK IDENTIFICATION

Level of Independence	Yes	No
Lives alone	☐	☐
Lives in residential care facility	☐	☐
Uses dose administration device i.e. spacers, inhaler devices	☐	☐
Uses administration aid (specify):.....	☐	☐
Uses medication list	☐	☐
Swallowing issues	☐	☐
Has impaired hearing	☐	☐
Has impaired vision	☐	☐

Other information:.....

Patient Assessment	Yes	No
Can read/comprehend labels	☐	☐
Can understand English	☐	☐
Can open bottles	☐	☐
Can measure liquids	☐	☐
Recent Home Medicine Review	☐	☐
Suspected non-adherence	☐	☐

Language spoken:

☐ Not an issue

Assess adherence by asking:

- People often have difficulty taking their pills for one reason or another. Have you had any difficulty taking your pills?
- About how often would you say you miss taking your medicines?

Other information:.....

MEDICATION HISTORY CHECKLIST

- ☐ Prescription medicines
- ☐ Sleeping tablets
- ☐ Inhalers, puffers, sprays, sublingual tablets
- ☐ Oral contraceptives, hormone replacement therapy
- ☐ Over-the-counter medicines
- ☐ Analgesics
- ☐ Gastrointestinal drugs *(for reflux, heartburn, constipation, diarrhoea)*
- ☐ Complementary medicines *(e.g. vitamins, herbal or natural therapies)*
- ☐ Topical medicines *(e.g. creams, ointments, lotions, patches)*
- ☐ Inserted medicines *(e.g. nose/ear/eye drops, pessaries, suppositories)*
- ☐ Injected medicines
- ☐ Recently completed courses of medicine
- ☐ Other people's medicine
- ☐ Social and recreational drugs
- ☐ Intermittent medicines *(e.g. weekly or twice weekly)*

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DO NOT WRITE IN THIS BINDING MARGIN

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(Affix patient identification label here and overleaf)

ALLERGIES & ADVERSE DRUG REACTIONS (ADR)
☐ Nil known ☐ Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction/Date	Initials

Sign .....Print .....Date .....

URN:
Family name:
Given names:
Address:

Date of birth: Sex: ☐ M ☐ F

1st Clinician to Print Patient Name and Check Label Correct:

MEDICINES TAKEN PRIOR TO PRESENTATION TO HOSPITAL

Medicine Generic name (Trade name) / Strength / Form / **Route**	**Dose**	**Frequency**	**Indication** (confirm with patient)	**How long or when started**	**Initials, profes-sion**	**Dr's Plan On Admission** ✓: Continue w: Withhold ×: Cease ▲: Change	**Supply at home** ✓	**Reconcile** ✓

NOT FOR ADMINISTRATION

RECONCILE WITH MEDICATION CHART

Documented by: Signature: ..... Name: ..... Date: .....

Counter signature (if required): .....

MEDICATION MANAGEMENT PLAN

KEEP WITH ACTIVE MEDICATION CHART - DO NOT REMOVE