Associates
Kensington Ave
City, State Zip
Tel (410) 555 - 1212 Fax (410) 555 - 1212

Clinial Pharmacy Consulting
Acute Care / Long Term Care
/ Ambulatory Care

PHARMACIST'S DRUG REGIMEN REVIEW

RESIDENT:	RM:	ATTENTION:	FACILITY: **Long Term Care**

☐ Resident currently receiving _____. Regulations indicate that [__K+, __CBC or H/H, __PT, __Urinalysis, __FBS, __Drug Level] be obtained now and [__ Monthly, __ q 3 Months, __ q 6 Months, __Yearly] and / or [__ Pulse be obtained prior to AM dose, __BP be obtained weekly].

☐ Resident currently receiving the [__Sedative/Hypnotic, __Antipsychotic] drug(s) _____ for more than 30 days. OBRA regulations mandate that this resident be [__Be re-evaluated as to the need to continue therapy, __Have an appropriate diagnosis identified] and charted as such.

☐ Resident currently receiving _____ which has been designated by HCFA as a medication with high potential for [__Severe, __ Less severe] adverse drug reactions in the elderly. Please consider discontinuing this medication if not currently necessary **-OR-** document an acceptable rationale for use including relative risk / benefit determination in this patient.

☐ Resident currently receiving _____ and has a diagnosis of [__COPD, __PUD/GERD, __Seizure, __Oral Anticoag, __BPH, __Arrhythmia, __Diabetes, __Constipation, __Insomnia]. The HCFA has identified this drug/disease combination as high risk for adverse effect and one which should be avoided. Please consider discontinuing this medication if not currently necessary **-OR-** document an acceptable rationale for use including relative risk / benefit determination in this patient.

☐ Resident has order(s) for the following PRN medication(s) _____. No doses have been administered over the past _____ days. Please consider discontinuing these PRN medication(s) per policy.

☐ Resident has been receiving _____ for the past _____ months. Please consider reducing the dose/schedule to a maintenance regimen of _____
_____.

☐ Resident currently receiving _____. The last [__Drug Level, __INR] obtained on _____ was _____. Please consider _____
_____.

☐ Additional Comments / Suggestions:
_____
_____
_____
_____

Pharm.D./
Consulting Pharmacist / Date

☐ Physician's / Director of Nursing's Response:
_____
_____
_____

Nursing Director's Signature / Date

Physician's Signature / Date