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| **Home medication review****Interview form** | **Family name:****Given name:****Address:****Date of birth: Sex: ☐ M ☐ F**  |

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| **Allergies:****Community pharmacy name:** |  |
| **1-Confirm medications taken:**Medication examination (multiple brands, expired, not used anymore, storage)Are there any medications other than those listed or shown to me? Including vitamin, herbal, OTC, ear/eye drops, injections, and inhalers. |  |
|  |
| **2-Health literacy:**What is each medication used for? **Good (1), needs improvement (2), little knowledge (3)** |  |
| **3-Medication administration:**Do you have any problems taking any of your medications? (e.g., **swallowing difficulties? dislike the taste of? forgetting)** |  |

 **Progress notes Page 2**

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| **Home medication review** **Interview form** | **Family name:****Given name:****Address:****Date of birth: Sex: ☐ M ☐ F**  |

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| **4-Medications side effects:**Do you have any side effects taking your medications?Screen specific medications side effects.Measure risk of fall. |  |
| **5-Patient data:**Do you smoke? Exercise? Diet?Weight and height. |  |
| **6-Medical conditions management:**Asses listed medical conditions if patient is satisfied with their control.Apply specific medical conditions questionnaires. |  |
| **7-Do you have any concerns that you would like me to focus on?** |  |

 **Progress notes Page 3**

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| **Home medication review** **Interview form** | **Family name:****Given name:****Address:****Date of birth: Sex: ☐ M ☐ F**  |