ezymed
medication made easy

HOME MEDICINES REVIEW REFERRAL FORM

Provider / Patient details may be completed by the practice staff

COMMUNITY PHARMACY DETAILS:
(nominated by the patient)

Name:

PATIENTS 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

Swallow

Cognition (member and comprehension)

Dexterity (eg manual coordination)

OTHER PATIENT INFORMATION

Height: Cm

Weight: Kg

Blood Pressure:

VACINATION STATUS (TICK IF UP TO DATE)

Tetanus

Rubella

Hepatitis A

Hepatitus B

Influenza

Other

DOES PATIENT SMOKE?

Yes No Ex Smoker

DOES PATIENT DRINK?

Don’t drink Approx drinks per week

MEDICATION DOSE ADMINSTRATION

Self Partner / Carer

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.

General Practitioner's Signature

Date:

Once completed, please fax referral to **02 97071116** or email to **info@ezymed.com.au**

ACKNOWLEDGEMENT OF RECEIPT OF REFERRAL

From (*Ezymed* headoffice)

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

Pharmacist conducting interview

Signed

ezymed
medication made easy
experience. confidence. expertise.