



Declaration of Consent

DATE:

Patient Consent
I, _____ consent to participating in the Saskatchewan (printed name of patient) Medication Assessment Program.
Signature of Patient:

Caregiver Consent
<i>If patient is unable to consent, a caregiver, legal guardian/power of attorney may provide consent for the patient's participation in the Saskatchewan Medication Assessment Program.</i>
I, _____, care provider/legal guardian/power of attorney (printed name of care provider/legal guardian/power of attorney) for _____, consent to participating in the Saskatchewan (printed patient name) Medication Assessment Program.
Signature of care provider/legal guardian/power of attorney for patient:

Note: An individual's health information may be shared with another healthcare provider as necessary for their care.



Comprehensive Patient Interview

SECTION I: MEDICAL HISTORY

DATE:

Patient Name:				
Address:				
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Weight:	Height:	Date of Birth:
Age:				
Health Services Number:				
Family Physician:				

Allergies/intolerances in the past (what happened, and when):			
Immunizations:			
Influenza:	Tetanus:	Pneumococcal:	Other:

Social History		
Smoking/tobacco Use <input type="checkbox"/> Yes <input type="checkbox"/> No Amount Used:	Caffeine Use <input type="checkbox"/> Yes <input type="checkbox"/> No Amount Used:	Medicinal Cannabis Use <input type="checkbox"/> Yes <input type="checkbox"/> No Amount Used:
Alcohol Use <input type="checkbox"/> Yes <input type="checkbox"/> No Amount Used:	Recreational Drug Use <input type="checkbox"/> Yes <input type="checkbox"/> No Type and Amount Used:	

Family History	
Has a 1 st degree relative (mother, father, sister, brother) ever experienced any of the following?	
Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Illness <input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No
Other family member medical conditions?	

Medical Conditions/ Surgeries	Additional Comments
Relevant Lab Data (e.g. CrCl, HgbA1C)	
What are your concerns regarding your health?	



Comprehensive Patient Interview

SECTION III: FOR PHARMACIST USE ONLY

Assessment of Medication Understanding and Adherence

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient prefer not to take any of their drugs?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient ever forget to take any of their drugs?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient know the indication of each drug they are taking?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient understand how to take their medication? (e.g. demonstration of devices)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Can the patient swallow / administer all of their drugs?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Can the patient read the labels?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Can the patient open medication bottles?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the storage of this medication appropriate?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have bottles of unused/expired medications?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are the patient's drugs too expensive for them?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is compliance packaging recommended for this patient?
	<i>If yes, provide proof of consent:</i> _____ Patient's Signature

Review of Systems

EENT (vision, hearing, or nasal problems):
Cardio (chest pain, heart problems, HTN, lipids):
Pulmonary (breathing problems):
GI (stomach problems or pain, nausea, constipation, trouble swallowing):
Skin (any skin troubles):
Endocrine (diabetes, thyroid history):
Hepatic (any history of liver problems):
Renal/Urinary (urinary frequency, renal dysfunction):
Hematology (bruising, bleeding):
MSK (pain):
Neuro (numbness, tingling, balance or falls, headaches, memory):
Psych (mood problems):
Reproductive (incontinence, impotence, hot flashes):
ID (any infectious diseases like HIV Hep C, TB etc.):
Diet (general diet, weight changes):



Comprehensive Patient Interview

SECTION III: FOR PHARMACIST USE ONLY...CONTINUED

Any additional diagnoses/issues not discussed?



SMAP CARE PLAN FORM

The following **must** be completed:

PIP profile reviewed:

Yes (attach PIP profile to form)

Time spent on assessment: _____

eHR Viewer (or equivalent) reviewed:

Yes

Patient requires compliance packaging:

Yes No

Reason for Compliance Packaging: _____

Document ALL Drug Related Problems (DRP) – Actual and Potential

Medical Condition and Medications (if applicable)	Goals of Therapy	Drug Therapy Problem (DTP) Actual and Potential	Recommendation(s) and Monitoring Plan	Practitioner Accepted Recommendation (Yes/No)	Follow-up and Dates	DTP Resolved (Yes/No)

SMAP CARE PLAN FORM

Medical Condition and Medications (if applicable)	Goals of Therapy	Drug Therapy Problem (DTP) Actual and Potential	Recommendation(s) and Monitoring Plan	Practitioner Accepted Recommendation (Yes/No)	Follow-up and Dates	DTP Resolved (Yes/No)



PERSONAL MEDICATION RECORD

Patient Name:		Using Compliance Packaging: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth:	HSN:	Pharmacy Name:	Fax Number:
Allergies and Intolerances:		Phone Number:	Fax Number:
		Family Practitioner Name:	Fax Number:
		Phone Number:	Fax Number:

Name of Medication (prescription and non-prescription)	Strength and Dose	Instructions for Use	Indication/ Goals of Therapy	Prescriber	Notes or Follow-up/Action Required

I confirm that the information provided above is accurate to my knowledge. It remains my responsibility to advise the pharmacist of any changes(s).

Signature of Patient (or Caregiver) _____ Date: _____

Pharmacist Name/Signature: _____ Date: _____

Additional Comments:



PERSONAL MEDICATION RECORD

Patient Name:		Using Compliance Packaging: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth:	HSN:	Pharmacy Name:	Fax Number:
Allergies and Intolerances:		Phone Number:	Fax Number:
		Family Practitioner Name:	Fax Number:
		Phone Number:	Fax Number:

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I confirm that the information provided above is accurate to my knowledge. It remains my responsibility to advise the pharmacist of any changes(s).

Signature of Patient (or Caregiver) _____ Date: _____

Pharmacist Name/Signature: _____ Date: _____

Additional Comments: