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 *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, _____, 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 ☐ **Female** ☐	**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 ☐ **Yes** ☐ **No** **Amount Used:**	**Caffeine Use** ☐ **Yes** ☐ **No** **Amount Used:**	**Medicinal Cannabis Use** ☐ **Yes** ☐ **No** **Amount Used:**
Alcohol Use ☐ **Yes** ☐ **No** **Amount Used:**	**Recreational Drug Use** ☐ **Yes** ☐ **No** **Type and Amount Used:**	

Family History **Has a 1st degree relative (mother, father, sister, brother) ever experienced any of the following?**	
Heart Attack ☐ **Yes** ☐ **No**	**Mental Illness** ☐ **Yes** ☐ **No**
Stroke ☐ **Yes** ☐ **No**	**Diabetes** ☐ **Yes** ☐ **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 II: MEDICATIONS

What are your concerns regarding your medications?				
Current Medications *(include prescription, non-prescription/OTC, herbals, vitamins, patches, drops, inhalers, creams etc.)*	**Strength and Doses**	**Indication** *(what medical condition is this medication being used for)*	**For Approx. How Long**	**Notes** *(e.g. how well medication is working, relevant labs)*

Do you have any medical conditions for which you are not currently taking medication?	**Have you taken any medications in the past which you have now stopped taking (include why, and when stopped)?**

Comprehensive Patient Interview

SECTION III: FOR PHARMACIST USE ONLY

Assessment of Medication Understanding and Adherence	
☐ **Yes** ☐ **No**	Does the patient prefer not to take any of their drugs?
☐ **Yes** ☐ **No**	Does the patient ever forget to take any of their drugs?
☐ **Yes** ☐ **No**	Does the patient know the indication of each drug they are taking?
☐ **Yes** ☐ **No**	Does the patient understand how to take their medication? (e.g. demonstration of devices)
☐ **Yes** ☐ **No**	Can the patient swallow / administer all of their drugs?
☐ **Yes** ☐ **No**	Can the patient read the labels?
☐ **Yes** ☐ **No**	Can the patient open medication bottles?
☐ **Yes** ☐ **No**	Is the storage of this medication appropriate?
☐ **Yes** ☐ **No**	Does the patient have bottles of unused/expired medications?
☐ **Yes** ☐ **No**	Are the patient's drugs too expensive for them?
☐ **Yes** ☐ **No**	**Is compliance packaging recommended for this patient?** **If yes, provide proof of consent:** _____ 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: ☐ Yes ☐ No
Date of Birth: HSN:	Pharmacy Name: Phone Number: Fax Number:
Allergies and Intolerances:	Family Practitioner Name: 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: ☐ Yes ☐ No
Date of Birth: HSN:	Pharmacy Name: Phone Number: Fax Number:
Allergies and Intolerances:	Family Practitioner Name: 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: