DOMICILIARY MEDICATION MANAGEMENT – HOME MEDICINES REVIEW

Provider/Patient details may be completed by the practice staff

The DMMR referral should include relevant information (e.g. laboratory results) to enable the pharmacist to make a thorough assessment. Please review the patient's medical record and any previous health assessments, care plans, and case conference summaries for relevant information. Completing the referral form* in detail will reduce the possibility of the pharmacist needing to contact you to clarify background information. Relevant information from the patient's medical record may be attached to the referral form e.g. as a printout from your patient record system.

*If you are not using a specific DMMR referral form you still need to provide patient details and relevant clinical information to the pharmacist.
Additional forms are available on the Department of Health and Ageing's website. See www.health.gov.au/mbsprimarycareitems

COMMUNITY PHARMACY / ACCREDITED PHARMACIST DETAILS
(nominated by the patient)

Name: _____

PATIENT 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
- ☐ Swallowing
- ☐ Cognition (Memory and Comprehension)
- ☐ Dexterity (e.g. manual coordination)
- ☐ Other

OTHER PATIENT INFORMATION

Height: _____ cm

Weight: _____ kg

Blood Pressure: _____

VACCINATION STATUS
(Tick if up to date)

- ☐ Tetanus
- ☐ Rubella
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Influenza

DOES PATIENT SMOKE?

☐ Yes ☐ No ☐ Ex-smoker

DOES PATIENT DRINK?

☐ Doesn't drink ☐ Approx _____ drinks per week

MEDICATION DOSE ADMINISTRATION:

☐ Self ☐ Partner/Carer

AIDS OR OTHER EQUIPMENT USED:

- ☐ Peakflow meter
- ☐ Spacer
- ☐ Nebuliser
- ☐ Blood Glucose meter
- ☐ Multi/unit dose DAA e.g. Dosette
- ☐ Other _____

INDICATION FOR DMMR

_____

_____

_____

ALLERGIES OR ADVERSE REACTIONS TO MEDICATION

DRUG	REASON FOR PRESCRIPTION	REACTION

CURRENT CONDITIONS AND MEDICATIONS

CONDITIONS /DIAGNOSIS e.g. DIABETES	MEDICATION OR OTHER TREATMENT e.g. Daonil or Diet	STRENGTH, DOSAGE AND FREQUENCY e.g. 5mg before breakfast	THERAPEUTIC GOALS e.g. Sugar control	ISSUES e.g. Visual problems

RELEVANT LABORATORY RESULTS AND BLOOD DRUG LEVELS

TEST TYPE	DATE	ISSUES

I HAVE EXPLAINED TO THE PATIENT:

- the process involved in having a DMMR and;

THE PATIENT UNDERSTANDS THAT:

- the location of the DMMR is at their choice, but preferably in their own home; and
- the pharmacist who will conduct the DMMR will communicate with me information arising from the DMMR; 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. *

Date: _____ **General Practitioner's Signature:** _____

* If the patient does not agree to release their Medicare No., the DMMR service can still be provided.

DOMICILIARY MEDICATION MANAGEMENT – HOME MEDICINES REVIEW

ACKNOWLEDGEMENT OF RECEIPT OF REFERRAL

From (community pharmacy/accredited pharmacist): _____

I have arranged to conduct a DMMR for: _____ (Patient's name)

on _____ .

Pharmacist conducting interview: _____

Signed: _____