



<b>Abbreviation Key</b> GP – General Practitioner CP – Community Pharmacist CF – Care Facility CMI – Consumer Medicines Information D/C – Discharge ADR – Adverse Drug Reaction T/F – Transfer POM – Patient’s Own Medications	UMRN: Family Name: Given Name(s): Address: DOB: <div style="text-align: right;">SEX <input type="checkbox"/> M <input type="checkbox"/> F</div>																		
<b>Patient Presentation</b>																			
Presenting Complaint _____ Past Medical History _____ _____ Current smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No NRT offered: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Recreational substances <input type="checkbox"/> Alcohol intake	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%;">Date _____</td> <td colspan="2" style="text-align: center;"><b>RENAL FUNCTION ON ADMISSION</b></td> </tr> <tr> <td>Wt _____ kg</td> <td style="width:20%;">Date _____</td> <td style="width:20%;">SCr _____</td> </tr> <tr> <td>IBW _____ kg</td> <td colspan="2" style="text-align: center;"><b>OTHER TEST RESULTS</b></td> </tr> <tr> <td>Ht _____ cm</td> <td colspan="2"></td> </tr> <tr> <td>BMI _____ kg/m<sup>2</sup></td> <td colspan="2"></td> </tr> <tr> <td>BSA _____ m<sup>2</sup></td> <td colspan="2"></td> </tr> </table>	Date _____	<b>RENAL FUNCTION ON ADMISSION</b>		Wt _____ kg	Date _____	SCr _____	IBW _____ kg	<b>OTHER TEST RESULTS</b>		Ht _____ cm			BMI _____ kg/m <sup>2</sup>			BSA _____ m <sup>2</sup>		
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BSA _____ m <sup>2</sup>																			
<b>Pre-Admission Medication History Has Been Confirmed with Two Sources</b> ( <input type="checkbox"/> Nil Regular Medications <input type="checkbox"/> Second Source deemed unnecessary Sign _____ )																			
<input type="checkbox"/> CP Ph: _____ Fax: _____ Email: _____ <input type="checkbox"/> CF Ph: _____ Fax: _____ Email: _____ <input type="checkbox"/> GP Ph: _____ Fax: _____ Email: _____ <input type="checkbox"/> GP letter/medication list Date: ____/____/____	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;"><b>Sign</b></td> <td style="width:50%;"> <input type="checkbox"/> Patient <input type="checkbox"/> Relative <input type="checkbox"/> Carer          Name if not patient _____       </td> <td style="width:10%; text-align: center;"><b>Sign</b></td> <td style="width:20%;"> <input type="checkbox"/> Own Medications  <input type="checkbox"/> POM S8/S4R  <input type="checkbox"/> POM Fridge          Consent to use <input type="checkbox"/> </td> <td style="width:10%; text-align: center;"><b>Sign</b></td> </tr> <tr> <td></td> <td> <input type="checkbox"/> Outpatient Clinic Notes          Location: _____          Date: ____/____/____  <input type="checkbox"/> Previous admission at: _____          Hospital: _____          Date of D/C / T/F: ____/____/____       </td> <td></td> <td> <input type="checkbox"/> Patient's own medication list          Date updated: ____/____/____  <input type="checkbox"/> My Health Record       </td> <td></td> </tr> <tr> <td></td> <td>         Dose Administration Aid (D.A.A.) <input type="checkbox"/> Nil  <input type="checkbox"/> Blister Pack <input type="checkbox"/> Sachet <input type="checkbox"/> Dosette  <input type="checkbox"/> Other: _____          Date Packed: ____/____/____       </td> <td></td> <td> <input type="checkbox"/> Other (specify): _____       </td> <td></td> </tr> </table>	<b>Sign</b>	<input type="checkbox"/> Patient <input type="checkbox"/> Relative <input type="checkbox"/> Carer Name if not patient _____	<b>Sign</b>	<input type="checkbox"/> Own Medications <input type="checkbox"/> POM S8/S4R <input type="checkbox"/> POM Fridge Consent to use <input type="checkbox"/>	<b>Sign</b>		<input type="checkbox"/> Outpatient Clinic Notes Location: _____ Date: ____/____/____ <input type="checkbox"/> Previous admission at: _____ Hospital: _____ Date of D/C / T/F: ____/____/____		<input type="checkbox"/> Patient's own medication list Date updated: ____/____/____ <input type="checkbox"/> My Health Record			Dose Administration Aid (D.A.A.) <input type="checkbox"/> Nil <input type="checkbox"/> Blister Pack <input type="checkbox"/> Sachet <input type="checkbox"/> Dosette <input type="checkbox"/> Other: _____ Date Packed: ____/____/____		<input type="checkbox"/> Other (specify): _____				
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<b>Medication Risk Assessment on Admission</b>																			
Can open bottles/measure liquid: <input type="checkbox"/> Yes <input type="checkbox"/> No Compliance with medications: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear Medications managed by: _____	Can understand English: <input type="checkbox"/> Yes <input type="checkbox"/> No Can read: <input type="checkbox"/> Yes <input type="checkbox"/> No Can see/read labels: <input type="checkbox"/> Yes <input type="checkbox"/> No																		
<b>Swallowing Status on Admission</b>																			
<input type="checkbox"/> Nasogastric Tube <input type="checkbox"/> PEG/RIG Thickened Fluids <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 3 <input type="checkbox"/> Level 4	Oral liquid preferred: <input type="checkbox"/> Yes <input type="checkbox"/> No Crushing required: <input type="checkbox"/> Yes <input type="checkbox"/> No																		
<b>Discharge and Transfer Medication Plan</b>																			
<b>Education Provided to Patient</b> <input type="checkbox"/> Interpreter required <input type="checkbox"/> ADR Brochure <input type="checkbox"/> Medicine information leaflet: _____ <input type="checkbox"/> CMI: _____ <input type="checkbox"/> Verbal counselling to patient/carer <input type="checkbox"/> Not required/declined <input type="checkbox"/> Medication list provided on discharge	<b>Community Liaison</b> <input type="checkbox"/> Patient denied consent to contact GP/CP <input type="checkbox"/> Copy of medication list faxed to GP/Clinic <input type="checkbox"/> Liaison with CF regarding D/C medications <input type="checkbox"/> Medication list/prescription faxed/emailed to CP <input type="checkbox"/> Fax front of WA Anticoagulation Chart to GP																		
<b>Medication Reconciliation at Discharge</b> <input type="checkbox"/> Discharge medications reconciled with medications prescribed at discharge on HMC <input type="checkbox"/> Pharmacist involvement in discharge summary	<b>Patient’s Medications at Discharge</b> <input type="checkbox"/> Patient's Own Medications reviewed <input type="checkbox"/> Patient's Own S8, S4R and Fridge items reviewed <input type="checkbox"/> Dose Administration Aid required - Packed by: _____																		
<b>Medications at Discharge</b>																			
<input type="checkbox"/> Nil Medications required <input type="checkbox"/> Dispensed at hospital <input type="checkbox"/> Prescription given to patient <input type="checkbox"/> Prescription posted to CP																			
<b>Pharmacist Comments and Medication Issues</b>																			
_____ _____ _____ _____																			
<input type="checkbox"/> Discharge reconciliation <input type="checkbox"/> Medication plan <input type="checkbox"/> Medication list Date/Time Completed: ____/____/____ : ____ Name: _____ Page: _____ <input type="checkbox"/> Doctor <input type="checkbox"/> Pharmacist <input type="checkbox"/> Nurse/Midwife																			

Version 4 2023. Developed by the WA Medication Safety Collaborative together with the Patient Safety and Clinical Quality Directorate. WA Health acknowledges contributions from the Alfred Hospital, The Queen Elizabeth Hospital, Queensland Health Medication Management Services and Armadale Kelmscott Memorial Hospital.