MULTI-AGENCY REFERRAL FORM

For referral of patients who have difficulty managing their prescribed medication. Complete the form and forward it to the patient's community pharmacist

Patient name: Address: Telephone: Lives alone- Yes/No circle)	**DOB:** CHI Number House bound- Yes/No (circle)
Informal Carer input (if applicable): Relationship to patient: Contact address (if different from above)	 Telephone:
Community pharmacist: Address:	 Telephone: FAX number:
Social Care/professional carer input (if applicable)**:** Address: Telephone: Visit frequency : daily or	Designation times per week _____
General practitioner: Address: Telephone number:	 FAX number:
Referral details Patient referred by **Date**	 Contact number
Relevant Medical History	**Circle as appropriate**
Stroke, arthritis, high blood pressure, cataract, glaucoma, history of falls/fractures Other	
Reason for referral for compliance assessment	**Circle as appropriate**
Is patient taking the medication as prescribed? Does the patient understand reason for medication? Does patient have difficulty opening bottles/foil packs? Has patient difficulty ordering repeat medications? Can patient read labels/information leaflets? Is patient confused/ forgetful? **Comments**	Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No

Current Medication:
If available please attach GP repeat medication slip/ computer print/medication chart or complete table below including non-prescription medicines.

Name of medication	Form	Dose	Times of administration

The Pharmacist assessor will contact patient / carer to arrange an appointment and will inform you of the result of the assessment.

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PATIENT/ CARER CONSENT

A. To be completed before the assessment

I understand the purpose of this assessment and I agree/do not agree to participate.

I consent to the sharing of information I give amongst Health care professionals for the purposes of improving my health and for research or audit.

Print Name _____

Signed Date

B To be completed after the assessment

I agree with the outcome of the assessment

Print Name _____

Signed Date

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COMPLIANCE NEEDS ASSESSMENT: SUPPLEMENT WITH NOTES AS APPROPRIATE

Follow up date (1 week) :
Follow up date (1-3 month):

Compliance Needs Assessment NHS Borders

Part 1 - Pharmacy Details		
Pharmacy name: **Tel:**	**Assessor's name:**	**Location of assessment:**
Part 2 – Patient and Referral Details		
Patient name:	**Referred by:**	
Address: **Tel:**	**Referrer address:**	
CHI No / DOB	**Referrer designation:**	
Previously using medication compliance aid: YES* NO* (*circle as appropriate) **If YES Reason for re-assessment.**		
GP:	**GP Tel:**	

Part 3 - Ability to Manage Medicines **(*circle as appropriate)**	
1.Who orders, collects repeat prescriptions?	(state who)
2. Does any of the medication ever run out?	YES or NO* (if yes state which)
3.Does the patient know what the medication is for?	YES or NO*
4.Does the patient know when to take their medicine?	YES or NO*
5.Does the patient ever forget/ choose not to take their medicine?	Never* Frequently* Sometimes*
6. Does the patient have anyone/thing to remind them to take their medicine?	YES or NO* (if YES state who)
7.Can the patient open child resistant tops?	YES or NO*
8.Can the patient open foil blisters?	YES or NO*
9. Can the patient read the labels/patient information leaflets?	YES or NO*
10.Can the patient swallow all of their medication	YES or NO* (if NO state which)

Part 4 – Medication Details		
Number of regular medications each day	Number of as required medications	
Number of times per day medication is to be taken		
Are **ALL** drugs suitable for inclusion in MDS	YES* NO*	(*circle as appropriate)
Is regimen stable (no dose titration)	YES* NO*	(*circle as appropriate)

Part 5 – Compliance Assessment
(Provision of a compliance aid should be considered after all other solutions to difficulties experienced with compliance have been explored)

Part 6 – Ability to manage monitored dosage system (MDS) (if appropriate) Following a demonstration of the aid the patient:	(*circle as appropriate)
Finds it easier to take tablets from an MDS system than the packet used presently?	YES or NO*
Understands how the system works and where the next dose should come from?	YES or NO*
Understands how to take medication that is not included in the aid?	YES or NO*

Part 7 – Pharmacist recommendation	
A compliance assessment has been carried out in conjunction with the patient/carer and the following recommendation(s) are made:	**(**tick boxes appropriate)
The patient's requires a MDS medication aid (specify type supplied)	
The patient does NOT require an MDS medication aid	
The patient requires additional medication counselling (state date counselling given)	
The patient requires a medication sheet	
The patient requires large labels	
The patient require other medication aids (specify which)	
Other/Comments	
Signed (pharmacist) **Date of assessment**	**Duration of assessment:**

Follow up dates

1. _____(one week) Reviewed by _____
2. _____ (1-3 month) Reviewed by _____

Compliance Needs Assessment Report

Patient name:	**Community pharmacy**
Address:	**Address:**
CHI No / DOB:	**Assessor**
Tel:	**Tel:**

Dear Doctor _____

A. I have identified that the above patient referred to me for compliance assessment has the following compliance issues. **Please indicate if you agree to the proposed action and return this form to the pharmacy.**

or

B. I have been **unable** to identify/resolve the patient's problems for the following reasons.

(DELETE EITHER A OR B)

Compliance Issue	Action taken / proposed	GP agreed Y /N

Please return form to community pharmacy

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