

PATIENT INFORMATION

PATIENT NAME:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH:
ADDRESS:	TELEPHONE:	
PHARMACIST:	DATE:	

CONSENT

(To be completed by the patient)

Do you consent to this medication review and allow this information to be shared with other Health Care Providers as appropriate under applicable law?

INITIALS:
YES

TREATMENT QUESTIONS

Do you know the names of your HIV medications?

NO YES

Do you know your CD 4 T-cell count?

NO YES

Do you know your Viral Load?

NO YES

ADHERENCE

Pharmacist to Evaluate: Potential DRP¹ = Adherence Issues (AI)

How many doses of your medication have you missed this week?

How many doses of your medication have you missed this month?

Are you able to take your medications as directed?

NO YES

Do you understand your medication instructions?

NO YES

Do you have difficulty taking or swallowing medications?

NO YES

Do you use any reminders to take your medications?

NO YES

If you do use reminders, please check all that apply:

Dosette/Blister Beeper/Cellphone Other

¹ Drug Related Problem (DRP)

LIFESTYLE

Smoker:

NO YES # YRS: # DAILY:

Alcohol consumption:

Women: None <9 drinks/week >9 drinks/week
Men: None <14 drinks/week >14 drinks/week

Desire to quit? NO YES

Recreational Substance: Marijuana Caffeine Opiates Amphetamines Other

DO YOU SUFFER FROM ANY OF THE FOLLOWING HIV TREATMENT-RELATED ADVERSE REACTIONS?* (if yes, check below and tell us how much it bothers you)

Nausea	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Tolerable <input type="checkbox"/> Requires Treatment	Numbness	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Tolerable <input type="checkbox"/> Requires Treatment
Diarrhea	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Tolerable <input type="checkbox"/> Requires Treatment	Rash/Itch	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Tolerable <input type="checkbox"/> Requires Treatment
Heartburn	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Tolerable <input type="checkbox"/> Requires Treatment	Skin Discolouration	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Tolerable <input type="checkbox"/> Requires Treatment
Headache	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Tolerable <input type="checkbox"/> Requires Treatment	Sexual Dysfunction	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Tolerable <input type="checkbox"/> Requires Treatment
Fatigue/Drowsiness	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Tolerable <input type="checkbox"/> Requires Treatment	Body Changes	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Tolerable <input type="checkbox"/> Requires Treatment
Dizziness	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Tolerable <input type="checkbox"/> Requires Treatment	Other	<input type="checkbox"/>	
Sleep Problems	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Tolerable <input type="checkbox"/> Requires Treatment			
Pain	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Tolerable <input type="checkbox"/> Requires Treatment			

Healthcare provider to evaluate: Potential DRP = Adverse Drug Reaction (ADR)
Make recommendations for anything that "Requires Treatment" (RD)

*This is not a complete list of possible HIV medication-related adverse reactions.

MEDICAL CONDITIONS

<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Neuromuscular
<input type="checkbox"/> Respiratory	<input type="checkbox"/> Bone
<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Endocrine	<input type="checkbox"/> Cancer
<input type="checkbox"/> Renal	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Hepatic	<input type="checkbox"/> Skin

PHARMACEUTICAL OPINION

Medication taken incorrectly or irregularly	AI	Drug without indication:therapeutic duplicate	TD	Problems with prescription reimbursement	AI	Suboptimal Response to therapy	SR
Drug/Drug or Drug/Food Interaction Possible	DI	Indication without drug: requires drug	RD	Some drugs are dosed incorrectly	DE	Adverse Drug Reaction	ADR

Drug Related Problem	Code	Suggested Course of Action / Education Provided / Recommendation

