

# MEDS REC: DATA COLLECTION

(to be filled out by patient; pharmacist can assist if needed)

DATE: \_\_\_\_\_

## PATIENT INFORMATION

Gender: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Insurance:  Public  Private

Specify: \_\_\_\_\_

Copay:  Yes  No

Specify: \_\_\_\_\_

**CONSENT** Do you consent to this medication review and allow this information to be shared with your health care providers as appropriate under applicable law?  Yes  No Signature: \_\_\_\_\_

## HIV AND TREATMENT

Current HIV medications (if applicable):

Name	Time of Day			
	Breakfast	Lunch	Dinner	Bedtime

When is the last time you had labwork?  <6 months ago  >6 months ago

Viral Load Undetectable?  Yes  No  I don't know

## OTHER MEDICAL CONDITIONS (check all that apply)

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Migraine/Headache
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Heartburn/Reflux
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Constipation/Diarrhea
<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Bone Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Dental Problems

Other: \_\_\_\_\_

## ADHERENCE

Do you have difficulty taking your medication as directed?  Yes  No

If Yes, why? Check all that apply:

<input type="checkbox"/> Number of pills	<input type="checkbox"/> Required to take with food	<input type="checkbox"/> Don't understand directions
<input type="checkbox"/> Dosing frequency	<input type="checkbox"/> Difficult to swallow	<input type="checkbox"/> Financial issues
<input type="checkbox"/> Simply forget	<input type="checkbox"/> Side Effects	

Do you currently use a reminder system? (cell phone alarm, app, dosette, blister pack, etc)  Yes  No

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

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

## OTHER MEDICATIONS

To the best of your ability, please indicate if you are taking any other prescription medications, over the counter medications, herbal supplements (the pharmacist can assist you with this if needed).

Name	Time of Day			
	Breakfast	Lunch	Dinner	Bedtime

## LIFESTYLE

Do you smoke?  Yes  No

If Yes, how many packs a day? \_\_\_\_\_

# of times you tried to quit \_\_\_\_\_

Do you drink alcohol?  Yes  No

# drinks per week \_\_\_\_\_

Do you use any of the following substances? (Check all that apply)

<input type="checkbox"/> Marijuana	<input type="checkbox"/> Cocaine
<input type="checkbox"/> Poppers	<input type="checkbox"/> Heroin
<input type="checkbox"/> Methamphetamine (Crystal)	<input type="checkbox"/> Ecstasy/MDMA
<input type="checkbox"/> Opioids	<input type="checkbox"/> Sleeping pills

Other: \_\_\_\_\_

## DO YOU SUFFER FROM ANY OF THE FOLLOWING HIV TREATMENT-RELATED ADVERSE REACTIONS\*

(Check all that apply and indicate how much you are bothered by it)

	No		Yes		Tolerable		No		Yes		Tolerable	
Nausea	<input type="checkbox"/>	Pain	<input type="checkbox"/>									
Diarrhea	<input type="checkbox"/>	Rash/itch	<input type="checkbox"/>									
Heartburn	<input type="checkbox"/>	Numbness	<input type="checkbox"/>									
Headache	<input type="checkbox"/>	Skin discolouration	<input type="checkbox"/>									
Fatigue/drowsiness	<input type="checkbox"/>	Sexual dysfunction	<input type="checkbox"/>									
Dizziness	<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>									
Feeling depressed	<input type="checkbox"/>	Joint stiffness	<input type="checkbox"/>									
Memory problems	<input type="checkbox"/>	Muscle aches	<input type="checkbox"/>									

Other: \_\_\_\_\_

HCP to evaluate potential Drug-Related Problem (DRP) = Adverse Drug Reaction (ADR). Make recommendations for anything that "requires treatment." \*This is not an complete list of possible HIV medication-related adverse reactions

List any questions or comments you have for your pharmacist here:

To report a suspected ADR to health Canada: Call Toll free at 1-866-234-2345 or online: <http://www.hc-sc.gc.ca/dhp-mps/medeff/report-declaration/index-eng.php>

## MEDS REC: HEALTHCARE PROVIDER COMMUNICATION

A specialized HIV medication review was conducted for your patient by our pharmacist. Below is a summary of the medication issue(s) identified and suggestions for your consideration.

**Please review, sign and fax reply at your earliest convenience. Thank you.**

**DATE:**

Pharmacy:

Phone:

Fax:

Pharmacist Name:

Pharmacist Signature:

Patient:

Pt ID No. /Date Of Birth:

Dear Doctor/Healthcare Provider:

Phone:

Fax:

### SUMMARY OF MEDICATION ISSUES

- 1 Indication Requiring Medication    
  2 Modify Dose or Therapy to Optimize or Simplify    
  3 Clarify Indication/Duplicate Therapy    
  4 Adverse Drug Reaction/Side Effect  
 5 Drug-Drug/Food/Lab Interaction    
  6 Adherence Issue    
  7 Medication Supply Issue    
  8 Medication Coverage Issue

Issue # <input type="radio"/> Description	Pharmacist Suggestion	Prescriber Please Check	
		Agree	Disagree
Issue # <input type="radio"/> Description	Pharmacist Suggestion	<input type="checkbox"/>	<input type="checkbox"/>
Issue # <input type="radio"/> Description	Pharmacist Suggestion	<input type="checkbox"/>	<input type="checkbox"/>
Issue # <input type="radio"/> Description	Pharmacist Suggestion	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Once complete, please sign and fax to pharmacy / clinic location as indicated above. Attach prescriptions if required. Thank you.

Prescriber Name (Print) \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_