Produced in triplicate

Domiciliary Medication Management Review

Medication Management Plan

General Practitioner :
____
Address:________________________________
____
____
Provider Number:________________________
Prescriber No: ___________________________
Phone:______________ Fax: ______________
Email:___________________________________

Patient :
____
Address: ________________________________
____
____
Medicare No: _____________________________
DVA No: ________________________________
Phone:______________ Fax: _______________
Email: __________________________________

Community Pharmacy / Accredited Pharmacist :
____
____
Address: ________________________________
____
____
Phone:______________ Fax: _______________
Email: __________________________________

Date of Pharmacist Review: ____/____/____ Date of follow-up consultation: ____/____/____

Current condition/problem	Current management*	Proposed plan of action	Person responsible for action**	Expected outcomes	Patient agrees
		☐ No action required ☐ Action (comment):			
		☐ No action required ☐ Action (comment):			
		☐ No action required. ☐ Action (comment):			
		☐ No action required ☐ Action (comment):			

*pharmacological and/or non-pharmacological

**nominate other health care professional if applicable

☐ Copy of agreed medication management plan forwarded to pharmacist, copy retained in patient's case notes and copy retained by patient

☐ If relevant and with patient's permission, forward copy of medication management plan to other member/s of health care team including a community pharmacy nominated by the patient

☐ Reminder/recall notice placed in patient's care note to consider need for DMMR in 12 months

General practitioner's signature____________________________ Patient's signature_____________________________ Date____/____/____