



DOMICILIARY MEDICATION MANAGEMENT — HOME MEDICINES REVIEW
REFERRAL FORM



Commonwealth Department of
Health and
Aged Care

DMMR REFERRAL FORM

The DMMR referral should include relevant information (eg laboratory results) to enable the pharmacist to make a thorough assessment. Please review the patient's medical record and any previous health assessments, care plans and case conference summaries for relevant information. Completing the referral form* in detail will reduce the possibility of the pharmacist needing to contact you to clarify background information. Relevant information from the patient's medical record may be attached to the referral form, eg as a printout from your patient record system.

*If you are not using a specific DMMR referral form you still need to provide patient details and relevant clinical information to the pharmacist.

RISK FACTOR/S FOR MEDICATION RELATED ADVERSE EVENTS. PLEASE REFER TO LIST BELOW AS A GUIDE WHEN DECIDING IF A PATIENT REQUIRES A DMMR SERVICE.

- Currently taking 5 or more regular medications
- Taking more than 12 doses of medication/day
- Significant changes made to medication regimen in the last 3 months
- Medication with a narrow therapeutic index or medications requiring therapeutic monitoring
- Symptoms suggestive of an adverse drug reaction
- Sub-therapeutic response to treatment with medicines
- Suspected non-compliance or inability to manage medication related therapeutic devices
- Patients having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties
- Attending a number of different doctors, both general practitioners and specialists
- Recent discharge from a facility / hospital (in the last 4 weeks)
- Other medication issues/problems

Provider/Patient details may be completed by the practice staff

COMMUNITY PHARMACY DETAILS:

(nominated by the patient)

Name:

PATIENT DETAILS:

(or affix label with patient details here)

Name:

Address:

D.O.B:

Medicare No:

DVA No:.....

Patient/Carer contact:.....

GENERAL PRACTITIONER DETAILS:

Name:

Address:

Provider No:

Prescriber No:.....

Phone:

Fax:

Email:.....

PREFERRED MEANS OF RECEIVING REPORT:

.....

ISSUES THAT MAY INFLUENCE MEDICATION USE OR EFFECTIVENESS:

- Vision
- Language and/or literacy problems
- Cognition (memory and comprehension)
- Other
- Hearing
- Swallowing
- Dexterity (eg manual coordination)

DOES PATIENT SMOKE?

- Yes
- No
- Ex smoker

DOES PATIENT DRINK?

- Don't drink
- approx..... drinks per week

OTHER PATIENT INFORMATION:

Height:.....Cm

Weight:.....Kg

Blood Pressure:.....

VACCINATION STATUS (TICK IF UP-TO-DATE)

- Tetanus
- Hepatitis A
- Influenza
- Rubella
- Hepatitis B
- Other.....

MEDICATION DOSE ADMINISTRATION

- Self
- Partner/Carer

AIDS OR OTHER EQUIPMENT USED:

- Peakflow meter
- Nebuliser
- Multi/unit dose DAA eg Dosette
- Spacer
- Blood Glucose Meter
- Other.....

INDICATION FOR DMMR (SEE INSIDE OF PAD FOR EXAMPLES)

.....

ALLERGIES OR ADVERSE REACTIONS TO MEDICATION

DRUG	REASON FOR PRESCRIPTION	REACTION

CURRENT CONDITIONS AND MEDICATIONS

CONDITIONS/ DIAGNOSIS eg Diabetes	MEDICATION OR OTHER TREATMENT eg Daonil or Diet	STRENGTH, DOSAGE AND FREQUENCY eg 5mg before breakfast	THERAPEUTIC GOALS eg Sugar control	ISSUES eg Visual problems

RELEVANT LABORATORY RESULTS AND BLOOD DRUG LEVELS (eg serum electrolytes, liver function tests etc. as relevant)

TEST TYPE	DATE	ISSUES

I HAVE EXPLAINED TO THE PATIENT:

- the process involved in having a DMMR; and

THE PATIENT UNDERSTANDS THAT:

- the location of the DMMR is at their choice, but preferably in their own home; and
- the pharmacist who will conduct the DMMR will communicate with me information arising from the DMMR; and

THE PATIENT HAS CONSENTED:

- to me releasing to the pharmacist information about their medical history and medications; and

THE PATIENT HAS/HAS NOT CONSENTED:

- to me releasing their Medicare No. or DVA No. to the pharmacist for the pharmacist's payment purposes.*

Date.....

General Practitioner's Signature

* If the patient does not agree to releasing their Medicare No., the DMMR service can still be provided.



ACKNOWLEDGEMENT OF RECEIPT OF REFERRAL

From (community pharmacy).....

I have arranged to conduct a DMMR for(Patient's name) on

Pharmacist conducting interview

Signed.....