RESIDENTIAL MEDICATION MANAGEMENT REVIEW
SAMPLE FORM

Use of a specific form to record RMMR is not mandatory but RMMR should cover the matters listed below.

Resident's details

Surname: _____
Other Names: _____
_____
Date of Birth: _____
□ New Resident □ Existing Resident

Medicare No.: _____
D.V.A. No.: _____
Pension No.: _____

Next of Kin/Guardian/Carer details

Name: Phone:

New Resident

Admission Date: _____
Has resident had a CMA? □ Yes □ No
If yes, has relevant information from the CMA been provided to reviewing pharmacist? □ Yes □ No

Existing Resident

Previous RMMR: □ Yes □ No
If yes, date of last RMMR: _____
If less than 12 months, reason for RMMR: _____

GP Details

Name: _____
Phone: _____ Fax: _____
Email: _____
Is this the resident's usual doctor? □ Yes □ No

Reviewing pharmacist details

Name: _____
Phone: _____ Fax: _____
Email: _____
Accredited? □ Yes □ No

Resident consent

Pre-review discussion with patient □ Yes
Consent for a RMMR obtained? □ Yes
Consent given by: □ Resident □ Representative

Advanced care directive (or similar)? □ Yes □ No
Enduring Medical Power of Attorney? □ Yes □ No

Power or Attorney details

Name: Phone:

Clinical Information Relevant to the RMMR

Principal diagnoses

_____
_____
_____
_____
_____
_____
_____
_____

Allergies and drug intolerance

_____
_____
_____
_____
_____
_____
_____
_____

Other Significant Health Problems

_____
_____
_____
_____
_____
_____

Does the resident smoke? □ Yes □ No □ Ex-smoker
Drink alcohol? □ Yes □ No _____ drinks per week
Height: _____ cm
Weight: _____ kg
Blood pressure: _____
Aids or other equipment used: _____
_____

Issues that may influence medication use or effectiveness

Vision: _____
Language/Literacy: _____
Cognition: _____
Hearing: _____
Swallowing: _____
Dexterity: _____
_____

I confirm that the resident has consented to the release of information about their medical history, medications, Medicare and DVA Numbers to the reviewing pharmacist.

GP's Signature: _____ Date: _____

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Use of a specific form to record the pharmacist component of RMMR is not mandatory, but the pharmacists report should cover the matters listed below.

PHARMACIST COMPONENT OF THE REVIEW

Reviewing Pharmacist Details	**Referring GP Details**
Name: _____	Name: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____
Email: _____	Email: _____
Accredited? □ Yes □ No	

Pre-review Discussion between Pharmacist and GP

Has a pre-review discussion between the GP and the pharmacist taken place? □ Yes □ No

Resident's Medications

Prescribed Medication	**Non-prescribed Medication**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Identified Problems/Issues

Issue	**Suggested action**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Any Other Issues

_____

_____

_____

_____

I confirm that I have reviewed Mr/Mrs/Ms/Miss _____ and that I forwarded a report outlining the outcomes of the review to Dr _____ on _____/____/_____

Reviewing Pharmacist's Signature: _____ Date: _____/_____/_____

RESIDENTIAL MEDICATION MANAGEMENT REVIEW
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Use of a specific form to record RMMR is not mandatory but RMMR should cover the matters listed below.

MEDICATION MANAGEMENT PLAN

Post-Review Discussion Between Pharmacist and GP

Has a post-review discussion with pharmacist taken place? □ Yes □ No

If no, reason: _____

Medication Management Strategies

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Other Services Required

CDM Case Conference: □ Yes □ No
CDM Care Plans: □ Yes □ No
Medication Management Aids: □ Yes □ No
Self Management Training: □ Yes □ No

Other: _____

Comments: _____
_____
_____
_____
_____

Copy of plan offered to patient: □ Yes □ No
Copy of plan placed on patient's records: □ Yes □ No
Plan discussed with aged care nursing staff: □ Yes □ No

Are you the resident's usual GP? □ Yes □ No
If no, please send a copy of this medication management plan to the resident's usual GP.

I confirm that I have discussed the medication management plan with the patient and that the patient has agreed to this medication management plan. Where necessary, I have forwarded a copy of the medication management plan to the resident's usual GP.

GP's Signature: _____ Date: _____/_____/_____