Enhanced Medication Review – Patient Assessment Form

Patient Information

Last Name | *First Name & Initial*

Gender | *Date of Birth (yyyy-mm-dd)*

MCP Number:

Known Medication Allergies/Reactions

Drug Name | *Reaction*

Drug Name | *Reaction*

Drug Name | *Reaction*

Family Physician Information

Name | *Phone Number* | *Fax Number*

Medical Conditions/Lifestyle

List all known medical conditions:

Patient Use of Tobacco Products

Patient Use of Alcohol

Patient Physical Activity

Patient Consent Information

☐ Consent Given by Patient

☐ Consent Given by Patient Representative (name):

Best Possible Medication List (Including Rx, OTC and Natural Products)

Drug Name and Strength	Dosage	Reason for Use	Comments / Special Instructions

Add additional pages, if necessary

Notes:

Pharmacy Information (or pharmacy stamp)	
Pharmacy Name & Address:	*Phone Number*
	Fax Number

Patient (or Representative) Signature

Pharmacist Name & Signature

Date Prepared

Pharmacist Assessment, Recommendations, Comments