Comprehensive Medication Review

# CMR **Worksheet**

Patient Name: _____

D.O.B. _____ /_____ /_____ Phone #: (_____)_____

Is the patient cognitively impaired? Yes / No

- ☐ Brief Interview for Mental Status (BIMS) score <13
- ☐ Cognitive impairment noted in patient's chart
- ☐ Confirmed status with family member/caregiver
- ☐ Confirmed status with healthcare staff
- ☐ Mini-mental state examination (MMSE) score <27

Was the patient in a long term care (LTC) facility when the CMR was completed? Yes / No

Is the CMR with the patient? Yes / No

If no, who is the CMR recipient?

Name: _____

Relationship to patient: _____

CMR Recipient

Address:_____

City: _____ State: _____ ZIP: _____

**Required:** Discuss how to safely dispose of unused prescription medications during the CMR.

### CMR Completed

_____ /_____ /_____

Date

### Patient Takeaway Delivered

_____ /_____ /_____

Date

### CMR Claim Submitted on Outcomes platform

_____ /_____ /_____

Date

_____

Pharmacist

_____

Pharmacy

## Health Profile

### A Current Conditions

- ☐ ADHD
- ☐ AFib
- ☐ Alcohol/Drug Dependency
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Bipolar Disorder
- ☐ Bladder Control
- ☐ Blood Clot Prevention
- ☐ Blood Disorder
- ☐ Brain Disorder (Neurologic)
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Chest Pain
- ☐ Constipation
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Liver Disease
- ☐ End Stage Renal Disease
- ☐ Enlarged Prostate
- ☐ Fluid Retention
- ☐ Gastrointestinal Disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Event
- ☐ Heart Failure
- ☐ Heartburn
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Inflammatory Bowel Disease (IBD)
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Lung Disease
- ☐ Memory Disorder
- ☐ Mental Health Condition
- ☐ Migraine Headache
- ☐ Mood Disorder
- ☐ Movement Disorder
- ☐ Multiple Sclerosis
- ☐ Nerve Pain
- ☐ Osteoporosis
- ☐ Pain
- ☐ Parkinson's Disease
- ☐ Peripheral Artery Disease
- ☐ Psoriasis
- ☐ Restless Leg Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Sexual Dysfunction
- ☐ Sleep Disorder
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Other: _____

## B Drug Allergies + Side Effects

| Medication | Allergic Reaction | Medication | Side Effect Reaction |
|---|---|---|---|
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## Med List

As you review medications, discuss purpose, instructions for safe use and the patient's experience with the medication.
Identify and discuss any concerns or issues related to indication, efficacy, safety, adherence or cost.
In directions, include the 5 required elements: dose, dosage form, strength, route of administration and frequency.

| Name/Strength | Prescriber | Directions | Related Condition | Potential Problems |
|---|---|---|---|---|
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## Medications *(continued)*

| Name/Strength | Prescriber | Directions | Related Condition | Potential Problems |
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## Action Plan

List concerns, problems or recommendations discussed during the CMR that will go on the Patient Takeaway.

| | Medication | Description of the Problem | What the Patient Should Do |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |

 

## Additional Notes