PHARMACIST DEPRESCRIBING PROGRAM

MEDICATION ASSESSMENT

PATIENT INFORMATION		
Last Name		First Name
Gender	Date of Birth / /	GSC ID #
Home Phone ( )		Cell Phone ( )

CURRENT MEDICATION LIST (Attach extra pages if additional space is required)

☐ Provincial Medication Review completed in the last year (ensure list is current and accurate)

To assess medication literacy, consider **asking the patient** the following questions:

1. What is the name of your medication?
2. What is the dose of your medication?
3. How often do you take your medication?
4. What are you using this medication for?

PRESCRIPTION DRUGS

Name & Dose	Route	Frequency	Reason for Use/Comments

OTC/HERBAL/SUPPLEMENTS

Name & Dose	Route	Frequency	Reason for Use/Comments

PHARMACIST NOTES AND RECOMMENDATIONS (Include date for each entry)