

**Assessment for medicine concordance
(medicine-taking check)**

Contact details (please print)

Service user/patient's name.....

Male Female Date of birth (optional).....

Address.....

.....Tel no.....

Name of GP or surgery

Pharmacy (if used regularly).....

Where is this form being completed?

Patient's home Pharmacy Hospital Other Please specify.....

1) Medicine arrangements at home

'Tell me how do you order and collect your repeat prescriptions and medicines?'

Do you remember to order on time? Usually Sometimes Never

Do you remember to collect on time? Usually Sometimes Never

Do problems with ordering/collecting ever cause you to miss any of your medicines?
Usually Sometimes Never

What arrangements have you made? e.g. collected by a friend/relative/carer

.....

ACTION:

Does the patient need help ordering/collecting prescriptions? Yes No

If yes, what arrangements could be made?

e.g. synchronise medicines Pharmacy collect prescription Friend/relative collect

Other

2) Patient's understanding and views about their medicines

Do you know what your medicines are for? Yes No

Do you understand how to take your medicines? Yes No

Do you know what to do if you miss a dose/take too much? Yes No

Would you like more information about your medicines? Yes No

Do you think your medicines are working for you? Yes No

Do you regularly take any 'over the counter' medications? Yes No

If yes, what do you take and how often?

Do you regularly take any 'homeopathic' medications? Yes No

If yes, what do you take and how often?

Do you have any concerns about taking your medicines? Yes No

If yes, what are these concerns?.....

.....

ACTION: Does the patient need more information about any of their medicines?

Yes No

Please give details.....

Referral to their GP Pharmacist

with regard to concerns about their medicines and/or side effects

3) Patient's adherence to their medicine regime

(Sometimes people take more or less of their medicines, depending on how they feel)

Do you usually take your medicines as prescribed? Yes No

When might you vary this?.....

How often do you forget to take your medicines? Often Sometimes Never

Do you use a system to help you to remember to take your medicines? Yes No

If yes, what system do you use?

If yes, does this always remind you to take your medicines? Yes No

Does anybody help you take your medicines? Yes No

If yes, who usually helps you?

A relative District nursing Home care Other Please Specify.....
or friend service assistant

In what way do they help you?

Do you think you need somebody to help you take your medicines? Yes No

If yes, ideally, who would you choose to give you this help?.....

What do you do with medicines no longer needed?

ACTION: Does the patient need:

• A reminder chart, or other means of prompting? Yes No

• An assessment for MDS? Yes No

If 'yes' a level 2 or level 3 medication review should be undertaken by GP/Pharmacist/[Practice Nurse or District Nurse]

• Referral to domiciliary care services for assistance with administration? Yes No

Any other actions needed?.....

.....

4) Do you have any problems with...

	Yes	No	Action needed. <i>e.g. refer for specialist advice</i>
Opening lids			
Using blister packs			
Picking up tablets			
Swallowing tablets			
Splitting tablets			
Pouring liquid medicine			
Managing eye/ear drops			
Injecting insulin			
Other devices <i>e.g. inhalers</i>			
Reading labels			
Reading and/or understanding English			
Understanding the medicine - taking instructions			
Understanding time of day/week			

Date:.....

Assessment done by (*print name*).....Signature.....

Job title :

I am aware that the information contained in this assessment may be shared with other health/social care professionals when appropriate for my care arrangements

Patient's signature:

OR Carer's (ie family member or other person caring for you) signature & contact details

(When completed on behalf of user):

.....

Summary of outcomes of this assessment:
to be completed by a health care professional/social care manager.

Signature:.....Print name:.....

Information and advice.....

Specialist advice

Category 1 assistance (self administering but requires help with ordering and collecting prescriptions)...

Category 2 assistance (as above and also needs prompting to take medication)

Category 3 assistance (requires supervision with self administering or total medication management which may include some direct administration.)

Category 4 assistance (Total medication management which may include some direct administration and invasive procedures)

Copies sent to: GP Community Pharmacist Dom. Care Manager Others

Suggested review date: