

Residential Medication Management Review Referral



Dear Pharmacist,

Thank you for seeing this resident whom I believe requires a **RMMR**. I provide **relevant clinical information** to assist with your review. I look forward to receiving your Pharmacist Report.

Doctor / Referring GP	
Doctor	Phone
Practice	Fax
Address	Email

Reviewing Pharmacist	
Pharmacist	Phone
Address	Fax
	Email

Resident Details

Resident	
Surname	Other names
Date of Birth / /	Pension No
Bed / Room No	Medicare/DVA No
RACF	Resident consent
RACF	Consent given by <input type="checkbox"/> Resident <input type="checkbox"/> Representative
Address	Date consent given / /
Phone	
Fax	

Health & Medical History

I have attached the following **relevant clinical information** for consideration in your review: [x pages]

Health & Medical History [eg CMA Summary page or HMR Referral Patient Summary]

List of Current Medications

Issues for consideration in medication management review	
Issues that may influence medication use or effectiveness:	
Vision:	Blood Pressure:
Language/literacy:	Height:
Cognition:	Weight:
Hearing:	Smoker: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> ex-Smoker
Swallowing:	Drinks: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ drinks p/week
Dexterity:	Aids or other equipment used:

Other significant information (including latest relevant test results)

Signatures		
GP:	Pharmacist:	Resident:
Date:		

Copy of Medication Management Plan to:	
<input type="checkbox"/> offer Resident a copy (and/or carer or representative)	<input type="checkbox"/> copy filed in resident's medical record
	<input type="checkbox"/> copy for aged care facility

