Produced in triplicate

Domiciliary Medication Management Review

Medication Management Plan

General Practitioner :	**Patient** :	**Community Pharmacy / Accredited Pharmacist** :
______________________	______________________	______________________
Address:______________________	Address: ______________________	______________________
______________________	______________________	Address: ______________________
______________________	______________________	______________________
Provider Number:______________________	Medicare No: ______________________	______________________
Prescriber No: ______________________	DVA No: ______________________	
Phone:____________ Fax: ____________	Phone:____________ Fax: ____________	Phone:____________ Fax: ____________
Email:______________________	Email: ______________________	Email: ______________________

Date of Pharmacist Review: ____/____/____ Date of follow-up consultation: ____/____/____

Current condition/problem	**Current management***	**Proposed plan of action**	**Person responsible for action****	**Expected outcomes**	**Patient agrees**
		☐ No action required ☐ Action (comment):			
		☐ No action required ☐ Action (comment):			
		☐ No action required. ☐ Action (comment):			
		☐ No action required ☐ Action (comment):			

*pharmacological and/or non-pharmacological

**nominate other health care professional if applicable

☐ Copy of agreed medication management plan forwarded to pharmacist, copy retained in patient's case notes and copy retained by patient

☐ If relevant and with patient's permission, forward copy of medication management plan to other member/s of health care team including a community pharmacy nominated by the patient

☐ Reminder/recall notice placed in patient's care note to consider need for DMMR in 12 months

General practitioner's signature______________________ Patient's signature______________________ Date____/____/____