

IPAC Project - MEDICINES STAKEHOLDER LIAISON PLAN

Complete a plan for each stakeholder

Name of Stakeholder / Service Provider	
Name of primary Stakeholder contact person (include phone number)	
Type of service provider	<ul style="list-style-type: none"> • Community pharmacy provider _____ • Hospital _____ • Other GP service provider _____ • Tertiary referral centre _____ • Aged Care Facility _____ • Pathology provider _____ • Other (please specify): _____
Nature of involvement in providing medication related services to the ACCHS	<ul style="list-style-type: none"> • S100 provider _____ • S100 support provider _____ • QUMAX arrangement _____ • Dispensing pharmacist _____ • HMR provider _____ • Tertiary referral centre _____ • Local hospital _____ • Other (please specify): _____
Preferred method(s) of engagement	<ul style="list-style-type: none"> • Phone _____ • Email _____ • Face-to-face _____ • Other (please specify) _____
Outline any suggested areas for improvement in workflow/liaison	

Evidence of Outcome

Actions undertaken to improve workflow/liaison	
Evidence that actions have led to improvement in workflow/liaison	
Feedback from Stakeholder / Service Provider	
Feedback from ACCHS	

Date of plan finalisation: ____ / ____ / ____

Signature of Stakeholder representative: _____