# PHARMACIST Rx INTERVENTION FORM CPhA

| **Pharmacist Initials**: (print 3 Initials) | **Date: ___/___/___** Day month year | **Time of Intervention: am/pm/after 6pm** (Circle one of the above) | **PHARMACY NAME:** |
|---|---|---|---|

#: _____ **Status**: ☐ New Rx ☐ Repeat Rx ☐ Other: _____

**Rx Presented by**: ☐ Patient ☐ MD by phone ☐ Nursing Home ☐ Patient Representative ☐ RN/Secretary by phone ☐ Other (Specify) _____

**Patient Sex:** ☐ Female ☐ Male ☐ Unknown

**Patient Age:** ☐ Infant (<3 years) ☐ Child (6-11 years) ☐ Adolescent (12-17 years) ☐ Adult (18-64 years) ☐ Senior (65+ years) ☐ Unknown

**Rx Problem** (Check all that apply)

**Drug(s):** ☐ Duplication ☐ Wrong ☐ Contraindication ☐ Interaction ☐ Allergy ☐ Not covered on Drug Plan

**Dose:** ☐ Different from previous Rx ☐ Too high ☐ Too low

**Form:** ☐ Inconvenient dosage form

**Strength:** ☐ Wrong/Needs clarification

**Missing:** ☐ Dose ☐ Strength ☐ Quantity

**Patient:** ☐ Non-compliance ☐ Lacks understanding

**Other:** ☐ Specify _____

**Describe Problem:** _____

_____

**Drug(s) Involved:** _____ $ _____

_____ $ _____

*Name* *Strength* *Form* *Directions* *Quantity* *Total Cost*

**Consulted:** (Check all that apply)

☐ Patient Profile ☐ Prescriber ☐ Other (Specify) _____

☐ Patient ☐ Prescriber's RN/Secretary

☐ Patient representative ☐ Drug information reference

**Recommendations**: (Check all that apply)

**Rx:** ☐ Clarify, no specific changes ☐ Add missing information

**Change:** ☐ Drug ☐ Form/route

**Change:** ☐ Strength ☐ Quantity ☐ Directions ☐ to Drug Plan Product

**Drug:** ☐ Stop ☐ Add

**Dose:** ☐ Increase ☐ Decrease

**Other:** ☐ specify _____

**Describe Recommendation:** _____

_____

**Drug(s) Involved:** _____ $ _____

*(If changed)* _____ $ _____

*Name* *Strength* *Form* *Directions* *Quantity* *Total Cost*

**Results:** (Check all that apply)

**Rx:** ☐ Dispensed as written ☐ Changed and dispensed ☐ Not dispensed

**Patient/ Representative:** ☐ Verbally counselled ☐ Provided written information ☐ Provided compliance aid

**Other:** ☐ Specify _____

**Evaluation of Intervention**

Based on the available information, <u>in your estimation</u>, how significant an impact will your recommendation have on the health of the patient?

Circle Appropriate Number

**1 No Impact** **2 Somewhat Significant Impact** **3 Significant Impact** **4 Very Significant Impact**

*PLEASE CHECK FORMS FOR COMPLETENESS*