Contact Assessment Form To be completed by pharmacy staff

Patient's Name………………………………………… NHS No.……………………………Date…………………

You should ask the patient 'Why do you think that you need support to help take or use your medicines?'

Consider the patient's physical and mental condition. Summarise your initial assessment in the table below.

<table>
<tr><td></td><td colspan="4">Summary of risk areas</td></tr>
<tr><td>Cognitive (Muddled or confused)</td><td colspan="4"></td></tr>
<tr><td>Sensory (e.g. sight, touch)</td><td colspan="4"></td></tr>
<tr><td>Physical (co-ordination, tremor etc.)</td><td colspan="4"></td></tr>
<tr><td>Could the condition possibly last at least a year and/or the rest of their life, and/or re-occur?</td><td colspan="2">Yes ☐</td><td colspan="2">No ☐</td></tr>
<tr><td>Are any medicines supposed to be taken more than twice a day?</td><td colspan="2">Yes ☐</td><td colspan="2">No ☐</td></tr>
<tr><td rowspan="3">How many different kinds of medicines are taken or used most days? (Include pain killers, indigestion remedies, but not herbal, alternative or complimentary therapies unless consider essential by patient)</td><td colspan="2">Prescribed</td><td colspan="2">Purchased</td></tr>
<tr><td>Regular</td><td>When required</td><td>Regular</td><td>When required</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
</table>

Problems with day-to-day medicine related activities?	Yes	No
Getting a supply of medicines before they run out?	☐	☐
Taking or using medicines?	☐	☐
Remembering to take medicines?	☐	☐

<table>
<tr><td>DDA does not apply</td><td>☐</td><td>Actions</td><td>Signposting ☐</td><td>Purchase ☐</td></tr>
<tr><td>DDA applies, self-assessment form provided</td><td>☐</td><td colspan="2">Date of self assessment form returned ………./………/…………</td><td>Date pharmacy assessment completed ………./………/…………</td></tr>
</table>

I agree and understand the outcome of this pharmacy assessment

Patient's signature …………………………………………

Completed by……………………………………..Name ……………………………………………. Signature