Assessment for medicine concordance
(medicine-taking check)

Contact details *(please print)*

Service user/patient's name…………………………………………………………………….

Male ☐ Female ☐ Date of birth *(optional)…* ……………………………………

Address…………………………………………………………………………………..…

…………..………………………………………………Tel no.…………………………………...

Name of GP or surgery ………………………………………………………………………..

Pharmacy *(if used regularly)*…………………………………………………………………………………….

Where is this form being completed?

Patient's home ☐ Pharmacy ☐ Hospital ☐ Other ☐ *Please specify*…………….…..………

1) *Medicine arrangements at home*

'Tell me how do you order and collect your repeat prescriptions and medicines?'

Do you remember to order on time? Usually ☐ Sometimes ☐ Never ☐

Do you remember to collect on time? Usually ☐ Sometimes ☐ Never ☐

Do problems with ordering/collecting ever cause you to miss any of your medicines?

Usually ☐ Sometimes ☐ Never ☐

What arrangements have you made? *e.g. collected by a friend/relative/carer*

………

ACTION:
Does the patient need help ordering/collecting prescriptions? Yes ☐ No ☐

If yes, what arrangements could be made?

e.g. synchronise medicines ☐ Pharmacy collect prescription ☐ Friend/relative collect ☐

Other ………………………………………………………………………………………………………..

2) *Patient's understanding and views about their medicines*

Do you know what your medicines are for? Yes ☐ No ☐

Do you understand how to take your medicines? Yes ☐ No ☐

Do you know what to do if you miss a dose/take too much? Yes ☐ No ☐

Would you like more information about your medicines? Yes ☐ No ☐

Do you think your medicines are working for you? Yes ☐ No ☐

Do you regularly take any 'over the counter' medications? Yes ☐ No ☐

If yes, what do you take and how often? ……………………………………………….

Do you regularly take any 'homeopathic' medications? Yes ☐ No ☐

If yes, what do you take and how often? ……………………………………………….

Do you have any concerns about taking your medicines? Yes ☐ No ☐

If yes, what are these concerns?……..……………………………………………………………………….

………

ACTION: Does the patient need more information about any of their medicines?

Yes ☐ *No* ☐

Please give details…………………………………………………………………………………..…..

Referral to their ……………………………….……… *GP* ☐ *Pharmacist* ☐

with regard to concerns about their medicines and/or side effects

3) *Patient's adherence to their medicine regime*

(Sometimes people take more or less of their medicines, depending on how they feel)

Do you usually take your medicines as prescribed? Yes ☐ No ☐

When might you vary this?…………………………………………...……………..……………..…………………..

How often do you forget to take your medicines? Often ☐ Sometimes ☐ Never ☐

Do you use a system to help you to remember to take your medicines? Yes ☐ No ☐

If yes, what system do you use? ……………………………………………………………………………………...

If yes, does this always remind you to take your medicines? Yes ☐ No ☐

Does anybody help you take your medicines? Yes ☐ No ☐

If yes, who usually helps you?

A relative or friend ☐ District nursing service ☐ Home care assistant ☐ Other ☐ *Please specify*…………………….

In what way do they help you? ………………………………………………………………………………………….

Do you think you need somebody to help you take your medicines? Yes ☐ No ☐

If yes, ideally, who would you choose to give you this help?…………………………………………………………

What do you do with medicines no longer needed? ………………………………………………….

……

ACTION: Does the patient need:

- A reminder chart, or other means of prompting? *Yes* ☐ *No* ☐
- An assessment for MDS? *Yes* ☐ *No* ☐

If 'yes' a level 2 or level 3 medication review should be undertaken by GP/Pharmacist/[Practice Nurse or District Nurse]

- Referral to domiciliary care services for assistance with administration? *Yes* ☐ *No* ☐

Any other actions needed?……………………………………………………………………………
………………………………………………………………………………………………………
………………………………………………………………………………………………………

4) Do you have any problems with…

	Yes	No	**Action needed**. *e.g. refer for specialist advice*
Opening lids			
Using blister packs			
Picking up tablets			
Swallowing tablets			
Splitting tablets			
Pouring liquid medicine			
Managing eye/ear drops			
Injecting insulin			
Other devices *e.g. inhalers*			
Reading labels			
Reading and/or understanding English			
Understanding the medicine - taking instructions			
Understanding time of day/week			

Date:....................................

Assessment done by *(print name)*.......................................Signature....................................

Job title : ....

I am aware that the information contained in this assessment may be shared with other health/social care professionals when appropriate for my care arrangements

Patient's signature: …………………………………..…………………………………………

OR Carer's (ie family member or other person caring for you) signature & contact details

(*When completed on behalf of user)*:

……………………………………………………………………………………………..

Summary of outcomes of this assessment:
to be completed by a health care professional/social care manager.

Signature:……..…………………………………....Print name:……………………………………

Information and advice………………………………………………………………………….

Specialist advice ……………………………………………………………………………………

Category 1 assistance (self administering but requires help with ordering and collecting prescriptions)... ☐

Category 2 assistance (as above and also needs prompting to take medication) ………………………… ☐

Category 3 assistance (requires supervision with self administering or total medication management which may include some direct administration.) ……………………………………………………………………….. ☐

Category 4 assistance (Total medication management which may include some direct administration and invasive procedures) …………………………………………………………………………………………….. ☐

Copies sent to: GP ☐ Community Pharmacist ☐ Dom. Care Manager ☐ Others …………………

Suggested review date: ………………………………………………….