Assessment form for use by pharmacy

Person's name		Date of assessment	…… dd/… … mm /…. … yy	
NHS number	………………………………… ……………	Is a carer present?	Yes☐	No☐
Address ………………………………………………………………… ……… …………………………………………………………… ……………………… ……………………………………………………Post code………………..		How many regular carers provide support?	Paid	Unpaid
Tel. Number	………………………………… …………	Who organises the ordering of your of prescriptions if not the normal carers? Telephone number…………………………………..		
Date of birth	…… dd/… … mm /…. … yy			
Preferred spoken language	…………………… …….			
GP's name		Number of dose alterations made in the past three months (use PMR)		
Date of last medicines use review	…… dd/… … mm /…. … yy			
What pharmacy services are currently provided?		Is there evidence of non-compliance in pharmacy PMR?	Yes☐	No☐

If possible, complete the times a day that a carer visits you							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morn-ing							
Mid-day							
Night							
Who do you give authority for the assessor to contact? Others, please state				☐ GP		☐ Carer	

Coping routines			
	Currently using	Could be useful	Patient does not think this will help
Simple routine	☐	☐	☐
Tick chart	☐	☐	☐
MAR Chart	☐	☐	☐
Purchased compliance aid	☐	☐	☐
Paid carer	☐	☐	☐
Family/friend support	☐	☐	☐
MDS system supplied by a pharmacy	☐	☐	☐
Summary of action plan agreed			

Assessment form for use by pharmacy

Medicine containers (Consider opening AND closing)	Problem area		Additional information
	Yes	No	
Boxes	☐	☐	
Blister packs	☐	☐	
Tablet or capsule bottles	☐	☐	
Screw lids	☐	☐	
CRC lids	☐	☐	
Winged lids	☐	☐	
Liquid bottles	☐	☐	
Squeezable tubes	☐	☐	
Purchased compliance aid	☐	☐	
Pharmacy supplied compliance aid	☐	☐	
Summary of action plan agreed			

Taking or using medicines	Problem area		Additional information
	Yes	No	
Non-soluble tablets	☐	☐	
Soluble tablets	☐	☐	
Chewed or crushed tablets	☐	☐	
Capsules	☐	☐	
Liquid medicines			
5 ml spoon	☐	☐	
20 ml cup	☐	☐	
Oral syringe	☐	☐	
Creams/ointments	☐	☐	
Inhalers	☐	☐	
Ear/eye/nose Drops	☐	☐	
Suppositories or pessaries	☐	☐	
Other	☐	☐	
Summary of action plan agreed			

Assessment form for use by pharmacy

Taking medicines according to the instructions			
	Problem area		Additional information
	Yes	No	
Reading instructions	☐	☐	
Understanding instructions	☐	☐	
Understanding symbol chart	☐	☐	
Generally forgetful	☐	☐	
The number of prescribed items	☐	☐	
The number of PRN prescribed items	☐	☐	
The number of complementary and alternative medicines	☐	☐	
Medicines similar in appearance	☐	☐	
Medicines varying in appearance from one prescription supply to another	☐	☐	
Lack of understanding of the reason for taking medicine	☐	☐	
Summary of action plan agreed			

Additional notes

Assessment form for use by pharmacy

Summary Form
Compliance aid assessment review for………………………………………/NHS No………………………
Patient's GP ………………………………………………………………………

Summary of risk areas	Assessed risk level			'Practical solution', sign-posting or aid provided to support compliance
	High	Medium	Low	
Coping routine	☐	☐	☐	
Getting medicines out of containers	☐	☐	☐	
Swallowing or using medicines	☐	☐	☐	
Following instructions	☐	☐	☐	
Intentional non-compliance	☐	☐	☐	
Confusion	☐	☐	☐	
Sensory problems (e.g. sight)	☐	☐	☐	
Physical problems (e.g. tremor)	☐	☐	☐	
Carer's activity	☐	☐	☐	
The following MDS has been supplied………………………………………………………………………………………………..				
Outline of intervention required				

	Yes	No	Completed by	Date dd/mm/yy
Action plan agreed with patient	☐	☐		……/……/…….
Carer informed	☐	☐		……/……/…….
GP informed, no intervention required	☐	☐		……/……/…….
GP informed, an intervention is required	☐	☐		
Referred for ………………………………	☐	☐		……/……/…….

Pharmacists Name (IN CAPITALS)…………………………..………

RPSGB Registration number………………………………………

Pharmacist's Signature…………………………………………………

Date …… dd/…… mm /……. yy   Next review date …… dd/…… mm

Pharmacy stamp