PHARMACIST DEPRESCRIBING PROGRAM

DEPRESCRIBING DOCUMENTATION FORM
DEPRESCRIBING OPPORTUNITY IDENTIFIED

PATIENT INFORMATION		
Last Name	First Name	
Gender	Date of Birth / /	GSC ID #
Home Phone ( )	Cell Phone ( )	

PHYSICIAN INFORMATION		
Last Name	First Name	
Lic. #		
Office Phone ( )	Office Fax ( )	
Address		Unit #
City	Province	Postal Code

MEDICATION HISTORY (CHECK OFF WHEN COMPLETED)

☐ Complete medication assessment (refer to *Medication Assessment form*) if required; **OR**
☐ Provincial medication review completed

ASSESSMENT (CHECK OFF WHEN COMPLETED)

☐ Patient eligibility determined based on the ***Ontario Pharmacy Evidence Network / Bruyère Research Institute*** evidence-based deprescribing guidelines & algorithms

Opportunity identified for: ☐ Proton pump inhibitor (PPI) ☐ Benzodiazepine & Z-Drugs (BZRA)

☐ Patient consents to participate in program and is aware communication will be sent to their physician

☐ Engage physician on next steps and tapering plan using the ***Physician Communication Form*** provided or equivalent

Date Sent: /

☐ Attach copy to documentation form

Response Received: / /

☐ Physician agreement

☐ Follow up with patient to book initial visit. **Date:** / /

☐ No response or deprescribing not recommended at this time

☐ Follow up with patient to explain rationale and end process. **Date:** / /

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PATIENT VISITS

INITIAL VISIT

Date: / /

☐ Review benefits of deprescribing, potential risks, and tapering plan, taking into account patient preferences and values.

☐ Next follow-up visit scheduled for / /

Pharmacist Notes

Pharmacist Name:

Pharmacist Signature

Date: / /

FOLLOW UP(S)[1]

On each visit during the duration of the tapering plan, monitor, reassess, and follow up with the patient providing guidance, practical advice, and effective coaching to help patients manage any symptom relapse, adopting alternative non-drug or safer drug strategies to manage their condition and adjustments to the treatment plan (if required).

1ST FOLLOW-UP

Date: / /

☐ Next follow-up visit scheduled for / /

Pharmacist Notes

Pharmacist Name:

Pharmacist Signature

Date: / /

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2ND FOLLOW-UP

Date: / /

☐ Next follow-up visit scheduled for / /

Pharmacist Notes

Pharmacist Name:

Pharmacist Signature

Date: / /

3RD FOLLOW-UP

Date: / /

☐ Next follow-up visit scheduled for / /

Pharmacist Notes

Pharmacist Name:

Pharmacist Signature

Date: / /

FINAL FOLLOW-UP

Date: / /

Outcome[2]: ☐ Successful ☐ Unsuccessful

Pharmacist Notes

Pharmacist Name:

Pharmacist Signature

Date: / /

*Please add additional pages for follow up if needed. Provide patient with a copy of documentation.

gsc green shield canada

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ADDITIONAL PHARMACIST NOTES

PHARMACIST AGREEMENT

I agree to comply with all conditions laid out in the Personal Information Protection and Electronic Documents Act (PIPEDA), or other provincial privacy legislation requirements. I agree to comply with all conditions regarding privacy laid out in the Green Shield Canada (GSC) Pharmacist Deprescribing training documents.

Date: / /

Pharmacist Signature

PATIENT AGREEMENT

By signing below, I agree to participate in the GSC Pharmacist Deprescribing Program. I understand that:

- Personal information collected will be used for the delivery of this coaching program.
- GSC may access this information for the purposes of audit or for the purposes of research.
- Personal information collected will not be used for any other purpose by GSC or its agents.
- If I am not the plan member, the information contained on the form may be seen by the cardholder/ plan member.

Date: / /

Patient Signature

Footnotes:

[1] *Based on the Ontario Pharmacy Evidence Network / Bruyère Research Institute evidence-based deprescribing guidelines:*

- *For PPIs, monitor at four and 12 weeks*
- *For BZRA drugs, monitor every one to two weeks depending on dose and tapering plan*

[2] *Outcome:*

- ***Successful** deprescribing can include stopping, stepping down, or reducing doses.*
- ***Unsuccessful** deprescribing defined as no changes to drug therapy.*