PHARMACIST HEALTH COACHING – CARDIOVASCULAR PROGRAM

MEDICATION ASSESMENT

This form is intended to be used in conjunction with the patient's Risk Assessment, Goals, and Action Plan form.

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

CURRENT MEDICATION LIST (Attach extra pages if additional space is required)

☐ Provincial Medication Review completed in the last year (ensure list is current and accurate)

To assess medication literacy, consider **asking the patient** the following questions:

1. What is the name of your medication?
2. What is the dose of your medication?
3. How often do you take your medication?
4. What are you using this medication for?

PRESCRIPTION DRUGS

Name & Dose	Route	Frequency	Reason for Use/ Comments	Initial Visit	1st F/U	2nd F/U	3rd F/U
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

PHARMACIST HEALTH COACHING – CARDIOVASCULAR PROGRAM

MEDICATION ASSESMENT

OTC/HERBAL/SUPPLEMENTS

Name & Dose	Route	Frequency	Reason for Use/ Comments	Initial Visit	1st F/U	2nd F/U	3rd F/U
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

PHARMACIST NOTES AND RECOMMENDATIONS (Include date for each entry)