Pharma-Care, Inc.

Health Care Consultation Specialists

WWW.PHARMACAREINC.COM

FACILITY PROFILE SHEET

(Print all)

Date of visit:_____ **Contract Start Date:**_____

Name of Facility: _____

Address: _____

_____

Telephone: _____ Fax: _____

Administrator: _____

Assistant Administrator: _____

Director of Nursing: _____

Assistant Director of Nursing: _____

In-service Coordinator: _____

Medical Director: _____

Provider Pharmacy: _____

Corporate Affiliation: _____

How many units does the facility have? _____

Exact name and spelling of each unit _____

_____

_____

Are there any specialty units? _____ Please Identify. _____

_____

Where are the E kits stored? _____

_____

Does the facility have a backup medication box? If so, location? _____

_____

136 CENTRAL AVENUE • CLARK, NEW JERSEY 07066 • TELEPHONE 732-574-9015 • FAX: 732-499-6778

Does the facility have a Central Supply Room – if so, are there medications stored there? _____

_____

Are there any other areas throughout the facility where medications are stored (i.e. crash carts, nursing office, doctor's office, old storage boxes)?_____

_____

What is your facility policy for destruction? _____

_____

REPORTING:

Does your staff need an in-service on Pharma-Care reporting procedure? _____

_____

What are your expectations for the consultant during the survey process? _____

_____

If extra hours are needed, whom should the consultant speak with? _____

_____

COMMUNICATIONS:

Who should the pharmacy consultant exit with? _____

In the absence of the above mentioned, who should the consultant exit with? _____

_____

Who do we contact for patient days? _____

Next facility quarterly meeting? _____

Who do we contact for quarterly meeting dates? _____

Are we expected to stay for the entire meeting or pharmacy related areas? _____

_____

Date of last Department of Health Survey: _____

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Survey results:_____

_____

_____

_____

START UP INSERVICES:

Pharma-Care, Inc. Inservice completed: _____(date)__ by:_____
- Topic:_____
- Inservice sign-in sheet attached: Yes___ No____

EPIC Inservice completed: _____(date)__ by:_____
- Inservice sign-in sheet attached: Yes___ No____

Med Pass Inservice (if requested) completed: _____(date)__ by:_____
- Inservice sign-in sheet attached: Yes___ No____

Contact Person: _____

Call before first visit: Yes___ No____ Other:_____

Consultant Assigned: _____

Facility
Representative _____

Pharma-Care
Representative _____ Date _____
Signature

For Office Use:

When possible, please complete before first facility visit

***Facility Initial Visit** document to be completed in it entirety and faxed to the Clark Office the day of the Initial Visit*