E.P.I.C.

Electronic Pharmacist Information Consultant
A Service of Pharma-Care, Inc. / Creative Care Consulting, LLC.

Pharma-Care, Inc.
Health Care Consultation Specialists
WWW.PHARMACAREINC.COM

Creative Care Consulting, LLC

FAX TO:

732-574-3469 / 732-574-3926 / 732-943-3571 / 732-943-3572

MEDICATION REVIEW REQUEST

Date Transmitted________________

PLEASE PRINT CLEARLY

Facility: ____

Resident Last Name: ______________________ **First Name:** ______________________

Doctor: ______________________ **Room Bed: #**__________ **Gender: M OR F** **Floor/Unit** ____________

Date of Birth: ______________________

Admission/Re-Admission Date: ______________

Allergies:

SELECT ONE ONLY: **NEW, RE-ADMISSION** OR **CHANGE OF STATUS**

☐ **NEW ADMISSION** ☐ **POS ATTACHED**

Also if provided: ☐ **MAR** ☐ **Hospital Discharge Medications**

☐ **RE-ADMISSION** ☐ **POS ATTACHED**

Also if provided: ☐ **MAR** ☐ **Hospital Discharge Medications**

☐ **CHANGE OF STATUS REPORT** **"Please check event(s) to be evaluated in '<u>Change of Status</u>' "**

- ☐ **Anorexia and/or Unplanned Weight Loss or Weight Gain**
- ☐ **Behavioral Changes, Unusual Behavior Patterns (Including Increased Distressed Behavior)**
- ☐ **Bleeding or Bruising, Spontaneous or Unexplained**
- ☐ **Bowel Dysfunction Including Diarrhea, Constipation and Impaction**
- ☐ **Dehydration, Fluid/Electrolyte Imbalance**
- ☐ **Depression, Mood Disturbance**
- ☐ **Dysphagia, Swallowing Difficulty**
- ☐ **Falls, Dizziness or Evidence of Impaired Coordination**
- ☐ **Gastrointestinal Bleeding**
- ☐ **Mental Status Changes (e.g. New/Worsening Confusion, New Cognitive Decline, Worsening of Dementia (Including Delirium))**
- ☐ **Headaches, Muscle Pain, Generalized or Nonspecific Aching or Pain**
- ☐ **Rash, Pruritus**
- ☐ **Respiratory Difficulty or Changes**
- ☐ **Sedation (Excessive), Insomnia or Sleep Disturbance**
- ☐ **Seizure Activity**
- ☐ **Urinary Retention or Incontinence**
- ☐ **OTHER:** ______________________

Request Sent By ______________________ **Call Back Phone Number if Questions:** ______________________

FaxBack Number (if different than CSID*) ______________________ **Number of Pages** (Plus this Cover Sheet) ______

Email Report to: ____________________________________ ☐ Make this permanent

* CSID is the fax/phone number entered into your fax machine as Client Identification - ** One Patient per transmission

NOTE: *COMPLETION OF THIS FORM INDICATES THAT THE FACILITY UNDERSTANDS THERE WILL BE A CHARGE FOR THIS REVIEW BASED ON ITS CURRENT CONTRACT*

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