DRUG REGIMEN REVIEW REQUEST

FAX or electronically transmit this completed form as well as information that will assist the pharmacist in conducting a Drug Regimen Review (DRR) whenever there is a need for a review (other than monthly). Such information would include MARs, physician notes, hospital discharge/transfer forms, lab results, nurses notes, etc. Retain a copy of this form in the resident's medical record until the DRR is completed by the pharmacist. At that time, the completed Drug Regimen Review is to be retained in the resident's medical record.

Resident Name:_____ Physician Name:_____

Pharmacy:_____ Date of Request:_____/_____/_____ Time of Request:_____ ❑ am ❑ pm

DOB:_____/_____/_____ Height:_____ Weight:_____ BP:_____/_____ Pulse:_____ Resp.:_____

Allergies (food and drug):_____

Diagnosis(es):

_____

_____

_____

Reason for Request:

❑ New admission ❑ Stay less than 30 days (anticipated DC date):_____/_____/_____ ❑ Transfer from this facility

❑ Return to this facility ❑ Respite/End-of-life/Hospice ❑ Significant change in condition ❑ QAPI Committee request

❑ Other:_____

Clinical Reason for DRR Request (Be specific and describe clinical condition):

_____

_____

_____

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Additional Comments:

_____

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_____

Total Number of Pages FAXed/Transmitted Electronically:_____ (include this form and cover sheet in count)

Signature/Title of Person Requesting DRR:_____ Date:_____/_____/_____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed