DRUG REGIMEN REVIEW - MDS/SNF QRP

This record serves as documentation of the drug regimen reviews (DRR) conducted upon the resident's admission **(start of Skilled Nursing Facility [SNF] Prospective Payment System [PPS] stay) and throughout the resident's stay (through Part A PPS discharge)** and address of any/all clinically significant medication issues identified in a timely manner. Also, F756 requires the drug regimen of each resident to be reviewed at least once/month by a licensed pharmacist.

Date of Admission:____________ **Time of Admission:**___________ ❍ AM ❍ PM **Admitted From:**________________________

Date of DRR:____________ **Time of DRR:**___________ ❍ AM ❍ PM **DRR Conducted By:**____________________________

Potential or Actual Clinically Significant Issues Identified: ❍ **No - No Action Needed** ❍ **Yes - See Below**

Name of Medication(s) Identified as Potential or Actual Clinically Significant Issue:______________________________________

Reason(s) for Identification:

- ❑ Documented medication allergy/prior adverse reaction
- ❑ Ineffective drug therapy
- ❑ Excessive or inadequate dose
- ❑ Duplicate therapy
- ❑ Wrong frequency
- ❑ Wrong time
- ❑ Dose, frequency, route or duration not consistent with resident's condition, manufacturer's instruction or applicable standards of practice
- ❑ Antibiotic order lacks indication, dose, and/or duration
- ❑ Purposeful or accidental non-adherence
- ❑ Drug-Food interaction
- ❑ Drug-Drug interaction
- ❑ Drug-Disease interaction
- ❑ Wrong resident
- ❑ Wrong route
- ❑ No indication for use
- ❑ Presence of medical condition that may warrant medication therapy
- ❑ Omission of medication from a prescribed regimen
- ❑ Other:____
- ❑ Other:____

Clinician Comments:____

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Name of Physician/Physician Designee Notified:____

Time of Notification:___________ ❍ AM ❍ PM **Notified By:**______________________________ **Date:**_______________

Means of Contact: ❑ Phone ❑ Fax ❑ In Person ❑ Voice-mail ❑ Electronic ❑ Other:__________________________

Name of Responding Physician/Physician Designee:______________________________________

Time of Response:___________ ❍ AM ❍ PM **Date:**________________ **Clinician:**______________________________

Recommended/Prescribed Action:____

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Name/Title of Clinician Completing Prescribed Action:_________________________________ **Date:**______________ **Time Completed:**___________ ❍ AM ❍ PM

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

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ADDITIONAL DRUG REGIMEN REVIEWS THROUGH - SNF/PPS STAY

Drug Regimen Review Conducted By:______________________ **Time of DRR:**__________ ❍ AM ❍ PM

Reason(s) for DRR:______________________ **Date of DRR:**__________

Potential or Actual Clinically Significant Issues Identified: ❍ **No - No Action Needed** ❍ **Yes - See Below**

Name of Medication(s) Identified as Potential or Actual Clinically Significant Issue:______________________

Reason for Identification:

- ❑ Documented medication allergy/prior adverse reaction
- ❑ Ineffective drug therapy
- ❑ Excessive or inadequate dose
- ❑ Duplicate therapy
- ❑ Wrong frequency
- ❑ Wrong time
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- ❑ Purposeful or accidental non-adherence
- ❑ Drug-Food interaction
- ❑ Drug-Drug interaction
- ❑ Drug-Disease interaction
- ❑ Wrong resident
- ❑ Wrong route
- ❑ No indication for use
- ❑ Presence of medical condition that may warrant medication therapy
- ❑ Omission of medication from a prescribed regimen
- ❑ Other:______________________
- ❑ Other:______________________

Clinician Comments:______________________

Name of Physician/Physician Designee Notified:______________________

Time of Notification:__________ ❍ AM ❍ PM **Notified By:**______________________ **Date:**__________

Means of Contact: ❑ Phone ❑ Fax ❑ In Person ❑ Voice-mail ❑ Electronic ❑ Other:______________________

Name of Responding Physician/Physician Designee:______________________

Time of Response:__________ ❍ AM ❍ PM **Date:**__________ **Clinician:**______________________

Recommended/Prescribed Action:______________________

Name/Title of Clinician Completing Prescribed Action:______________________ **Date:**__________ **Time Completed:**__________ ❍ AM ❍ PM

Drug Regimen Review Conducted By:______________________ **Time of DRR:**__________ ❍ AM ❍ PM

Reason(s) for DRR:______________________ **Date of DRR:**__________

Potential or Actual Clinically Significant Issues Identified: ❍ **No - No Action Needed** ❍ **Yes - See Below**

Name of Medication(s) Identified as Potential or Actual Clinically Significant Issue:______________________

Reason for Identification:

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- ❑ Drug-Disease interaction
- ❑ Wrong resident
- ❑ Wrong route
- ❑ No indication for use
- ❑ Presence of medical condition that may warrant medication therapy
- ❑ Omission of medication from a prescribed regimen
- ❑ Other:______________________
- ❑ Other:______________________

Clinician Comments:______________________

Name of Physician/Physician Designee Notified:______________________

Time of Notification:__________ ❍ AM ❍ PM **Notified By:**______________________ **Date:**__________

Means of Contact: ❑ Phone ❑ Fax ❑ In Person ❑ Voice-mail ❑ Electronic ❑ Other:______________________

Name of Responding Physician/Physician Designee:______________________

Time of Response:__________ ❍ AM ❍ PM **Date:**__________ **Clinician:**______________________

Recommended/Prescribed Action:______________________

Name/Title of Clinician Completing Prescribed Action:______________________ **Date:**__________ **Time Completed:**__________ ❍ AM ❍ PM

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

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