

PHYSICIAN ACTION REPORT - DRUG REGIMEN REVIEW

INSTRUCTIONS: The pharmacist will identify and make recommendations to correct any irregularity. Keep a copy in resident's chart until physician returns comments and signature. Replace copy with completed review.

PHARMACIST REPORT

After reviewing the drug regimen on _____ for _____,
Date Resident Name
residing at _____, I have the following concern(s) that need to be addressed:
Facility

- This is a clinically significant issue and requires urgent attention**
- | | | |
|---|--|---|
| <input type="checkbox"/> Adverse effect | <input type="checkbox"/> Potential drug interaction | <input type="checkbox"/> Excessive duration |
| <input type="checkbox"/> Possible drug allergy | <input type="checkbox"/> Duplicate drug therapy/excessive dose | <input type="checkbox"/> Monitoring |
| <input type="checkbox"/> Drug indication not clear/no diagnosis | <input type="checkbox"/> Other (specify) _____ | |
| <input type="checkbox"/> Gradual dose reduction | | |

Drug: _____ Current dose: _____ Frequency: _____ Route: _____
Drug: _____ Current dose: _____ Frequency: _____ Route: _____

DETAILED DESCRIPTION OF IRREGULARITY AND RECOMMENDATION(S)

Pharmacist Signature: _____ Date: _____ Time: _____
© SAMPLE 147-2343
 AM
 PM

PHYSICIAN COMMENTS

Please comment and return immediately for placement in resident's chart.

ALL MEDICATION ORDER CHANGES MUST BE WRITTEN ON A PHYSICIAN ORDER FORM

Physician Signature: _____ Date: _____ Time: _____
 AM
 PM

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