

Modified CMR Worksheet

Patient Name: _____ DOB: _____

Address: _____

Is the patient cognitively impaired? Yes / No

Is the CMR with the patient? Yes / No Phone #: _____

Assistance by (name): _____ Relationship: _____

Did the patient receive a medication reconciliation before discharge? Yes / No

By whom: ☐ Pharmacist ☐ Physician ☐ Nurse ☐ Other: _____

Date of discharge: _____

Hospital diagnosis: _____

Date of CMR: _____

Med List & MAP mailed: _____

Follow-up completed: _____

Pharmacist: _____

Location: ☐ In store ☐ At home ☐ By phone

Patient's pharmacy: _____

Medication Profile

① Medical conditions

- | | | |
|---|---|--|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anticoagulation | <input type="checkbox"/> Dyslipidemia | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GI/Reflux/Ulcer | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Autoimmune Disorders | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Benign Prostatic Hyperplasia | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Severe Hematologic Disorder |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke |
| | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Surgery _____ |
| | <input type="checkbox"/> Neurologic Disorders | |

② Drug Allergies or Intolerances

- ☐ No known drug allergies

Medication	Reaction

3 Physicians and Hospitalists (name, phone number, type of physician)

APPENDIX A. Modified CMR Worksheet

Pharmacist’s Notes:

APPENDIX A. Modified CMR Worksheet

5 Detailed Medication Action Plan for Pharmacists

[illegible]

APPENDIX A. Modified CMR Worksheet

Medication Action Plan

Patient Name: _____

Pharmacist Name: _____

Date of visit with pharmacist: _____

Pharmacist's Phone Number: _____

Medication	Description of the problem	What I should do

Please feel free to call if you have any questions or concerns!