MEDICATION THERAPY MANAGEMENT
(PHARMACEUTICAL CARE)

- provide pharmacists with a refresher on core clinical medication assessment and with components to enhance implementation
- 01/01/06, Medicare drug plans will be required to provide MTM services to beneficiaries who suffer from multiple chronic conditions, take several Medicare-covered drugs, and are expected to spend at least $ 4000 each year on their medications
- Congress recognizes that pharmacists are uniquely qualified to provide those services
- Components of MTM

1. Medication therapy review (MTR)
    a. Monitor ongoing therapy
    b. Review of all meds: Rx, OTC, herbal, DS at least annually
    c. Outcome: to optimize drug therapies
2. Personal medication record
    a. List of patient's own meds, strength, dosing directions, and other info
    b. RPh encourages patients to share this list with all of their health care providers
3. Medication Action Plan (MAP)
    a. A MAP contains info to help patient improve their medication management
4. Intervention on medication therapy problems and/or referral
    a. RPh intervenes to address med related problems
    b. RPh refers patients to other health care providers
5. Documentation of services and follow-up

Form VPhA1
Vietnamese Pharmacists Association in the USA
Pharmaceutical Care Program

Patient Medication History Form

Patient Name (Tên): _____ **Birth date (Ngày sanh):** _____ **Patient Number:** _____

Social Security # (Số an sinh): _____

Gender: Male / Female

Mailing Address (Địa chỉ): _____
Street (Số nhà) City (Thành phố) State (Tiểu bang) Zip

Home Phone (Số điện thoại nhà): _____ **Work Phone:** _____

Height (Chiều cao): _____ **Weight (Cân nặng):** _____ **HR:** _____ **BP:** (L) _____ (R) _____

Allergies	Reaction (Phản ứng)

Devises/Alerts (Dụng cụ/cảnh giác): _____
_____

Surgery History (Tiểu sử phẫu thuật): _____
_____

Smoking History: **____ Never smoked (chưa hề hút)**
(Hút thuốc lá) **____ Stopped smoking in year_____ (Bỏ hút từ năm nào)**
___ Packs per day since _____ (Còn hút mấy bao mỗi ngày từ năm nào)

Alcohol History: **____ Never drank (chưa hề uống rượu)**
(Uống rượu) **____ Stopped drinking in year _____ (Bỏ uống từ năm nào)**
____ Drinks (beer, wine, whiskey, vodka, other: _____) per day since _____
(Còn uống loại nào, bao nhiêu ly mỗi ngày, và từ năm nào)

IV Drug Use: _____

Medical History (Indicate year of diagnosis. Xin cho biết năm định bệnh):

_____ Hypertension (cao huyết áp) **_____ Diabetes (tiểu đường)** **_____ Hyperlipidemia (cao mỡ máu)**
_____ Asthma (suyễn) **_____ COPD (nghẽn khí đạo)** **_____ Osteoporosis (loảng xương)**
_____ Depression (trầm cảm) **_____ GERD (trào ngược thực quản)**
_____ Anxiety (sự lo âu, sợ sệt) **_____ CAD (bệnh động tim mạch vành)**
_____ Hyperthyroidism (cường giáp) **_____ Urinary incontinence (són tiểu)**
_____ Hypothyroidism (nhược giáp) **_____ Other (bệnh khác)** _____

Pharmacist: _____ Signature: _____ Date: _____

Form VPhA2
Vietnamese Pharmacists Association in the USA
Pharmaceutical Care Program

Patient OTC Medication, Usage, and Family History Form

Patient Name: _____ Birth date: _____ Patient Number: _____

Allergies: _____

HERBAL & OVER-THE-COUNTER MEDICATION HISTORY				
Drug name & strength	Direction of use	Purpose of medication	How often used	Effectiveness

OTC USE: Check conditions for which you have used a non-prescription medication (ông bà dùng OTC hay dược thảo để chửa bệnh gì)

____ headache (nhức đầu)
____ heartburn/GI upset/gas (đầy hơi bụng, sôi bụng)
____ weight loss (xuống cân)
____ cold/flu (cảm lạnh)
____ herbal products (dược thảo)
____ hemorrhoids (bệnh trĩ)
____ sinus/congestion (nghẹt mũi)
____ rash/itching/dry skin (chứng phát ngứa)
____ sleeplessness (mất ngủ)
____ drowsiness (buồn ngủ)
____ eye/ear problems (đau mắt/tai)
____ vitamins (sinh tố)
____ diarrhea (tiêu chảy)
____ allergies (dị ứng)
____ organic products
____ muscle/joint pain (đau nhức bắp thịt/cốt xương)
____ cough (ho)
____ other: _____

Family History. Have you or any blood relative had any (mark all that apply) of the following:

	Self	Relative (thân nhân)		Self	Relative
Alcoholism (nghiện rượu)	___	___	stroke	___	___
Asthma (suyển)	___	___	hypertension (áp huyết cao)	___	___
Cancer (ung thư)	___	___	kidney disease (bệnh thận)	___	___
Depression (trầm cảm)	___	___	mental illness (bệnh tâm thần)	___	___
Diabetes (tiểu đường)	___	___			
Heart disease (bệnh tim)	___	___	other conditions (bệnh khác) _____		
Lung disease (bệnh phổi)	___	___	_____		

Pharmacist: _____ Signature: _____ Date: _____

Form VPhA3
Vietnamese Pharmacists Association in the USA
Pharmaceutical Care Program

Pharmaceutical Care Drug Assessment & Diagnosis Form

Patient Name: _____ **Birth date**: _____ **Patient number:** _____

Allergies: _____

Diagnoses:

1_____ 6_____
2_____ 7_____
3_____ 8_____
4_____ 9_____
5_____ 10_____

Medications: **Assessment:**

1_____ _____
2_____ _____
3_____ _____
4_____ _____
5_____ _____
6_____ _____
7_____ _____
8_____ _____
9_____ _____
10_____ _____
11_____ _____
12_____ _____
13_____ _____
14_____ _____
15_____ _____
16_____ _____
17_____ _____

Date for follow-up: _____

Follow-up Comments:

_____
_____
_____
_____
_____
_____
_____

Pharmacist: _____ Signature: _____ Date: _____

Form VPhA4
Vietnamese Pharmacists Association in the USA
Pharmaceutical Care Program

Patient's Question/Concern and Pharmacist's Assessment/Response Form

==========

Patient name: _____ Birth date: _____ Patient number: _____

Question/Concern #1: _____

_____

Assessment/Response #1: _____

_____

_____

_____

Question/Concern #2: _____

_____

Assessment/Response #2: _____

_____

_____

_____

Question/Concern #3: _____

_____

Assessment/Response #3: _____

_____

_____

_____

Question/Concern #4: _____

_____

Assessment/Response #4: _____

_____

_____

_____

Question/Concern #5: _____

_____

Assessment/Response #5: _____

_____

_____

_____

Pharmacist: _____ Signature: _____ Date: _____

Form VphA5
Vietnamese Pharmacists Association in the USA
Pharmaceutical Care Program

Patient's Proper Medication Usage Form

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Patient Name (Tên): _____ Birth date: _____ Patient Number: _____

Medication (Thuốc)	Dose	Frequency				Comment (duration, food…)
		Sáng (A.M.)	Trưa (noon)	Chiều (P.M.)	Tối (H.S.)	
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						

Other Comments/Recommendation:

_____

_____

_____

_____

_____

_____

Pharmacist: _____ Signature: _____ Date: _____

Form VPhA6
Vietnamese Pharmacists Association in the USA
Pharmaceutical Care Program

Pharmacist Communication To Physician Form

Patient Name: _____ **Birth date**: _____ **Patient #**: _____

S: _____

_____

_____

_____

_____

O: _____

_____

_____

_____

A/P: _____

_____

_____

_____

_____

_____

_____

_____

_____

Pharmacist: _____ Signature: _____ Date: _____

PHYSICIAN'S RESPONSE/COMMENT TO RECOMMENDATION/FINDING

_____

_____

_____

_____

_____

_____

_____

_____

Physician (print): _____ Signature: _____ Date: _____