CLINICAL PHARMACY SERVICES DOCUMENTATION FORM

Name: _____ **Date of Birth:**_____ **Sex: M / F**

Phone: _____ **Appt Date:** _____

Subjective

Objective

Weight (lbs)	
Blood Pressure (mmHg)	
Blood Glucose (mg/dL)	Fasting / Non-Fasting

Name: ______________________________ **Date of Birth:**____________________ **Sex: M / F**

Phone: ____________________________ **Appt Date:** _______________________

Drug Allergies / Reactions:____

Medical Conditions:____

Medications (Rx and OTC):

Medication Name / Strength:	***Directions:***	***Indication:***	***Compliant? Y/N (>80%)***

Name: _____ **Date of Birth:**_____ **Sex: M / F**

Phone: _____ **Appt Date:** _____

Assessment

☐ **Potentially Inappropriate Therapy:**_____

☐ **Cost-Saving Opportunity:**_____

☐ **Dosage too low:**_____

☐ **Dosage too high:**_____

☐ **Adverse drug event/reaction:**_____

☐ **Non-adherence:**_____

☐ **Drug interactions:**_____

☐ **Duplicate therapy**_____

☐ **Additional medication needed:**_____

☐ **Additional labs/tests needed:**_____

☐ **Additional non-pharmacologic therapy:**_____

☐ **Other:**_____

Name: _____ **Date of Birth:**_____ **Sex: M / F**

Phone: _____ **Appt Date:** _____

PLAN

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

_____

_____ _____ _____

Student Pharmacist Name (Print) **Student Pharmacist Signature** **Date**

_____ _____ _____

Clinical Pharmacist Name (Print) **Clinical Pharmacist Signature** **Date**

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DATA COLLECTION

Annual Medical Costs: $ _____

Annual Rx Drug Costs: $_____