Patient's Name……

NHS No…… **Date……**

Instructions:

This form can be completed in your own home or anywhere that you feel is appropriate. You may ask family members, carers or the pharmacy staff to support you. Complete as much of the form as you can. Fill in the spaces or insert a ☒ next to your answer.

Why do you think that you need support to help take or use your medicines?

	Summary of risk areas
Cognitive (Muddled or confused)	
Sensory (e.g. sight, touch)	
Physical (co-ordination, tremor etc.)	

Could the condition possibly last at least a year and/or the rest of their life, and/or re-occur?	Yes ☐	No ☐
Are any medicines supposed to be taken more than twice a day?	Yes ☐	No ☐

How many different kinds of medicines are taken or used most days? (Include pain killers, indigestion remedies, but **not** herbal, alternative or complimentary therapies unless consider essential by patient)	Prescribed		Purchased	
	Regular	When required	Regular	When required

Problems with day-to-day medicine related activities?	Yes	No
Getting a supply of medicines before they run out?	☐	☐
Taking or using medicines?	☐	☐
Remembering to take medicines?	☐	☐

Think about your tablets, capsules, liquids, creams, inhalers and other types of medicines	Yes	No
Do you have any routines to help you remember take or use your medicines?	☐	☐
Do you have any problems with opening or closing medicine containers?	☐	☐
Do you have any problems getting medicines out of containers?	☐	☐
Do you take or use all of your medicines according to the instructions?	☐	☐
Can you take or use all of your medicines (e.g. swallowing, using drops/inhalers)	☐	☐
Do you think that some of your medicines are more helpful than others?	☐	☐

	Number
How many of your prescribed medicines are supposed to be taken or used only when you need them?	
How many herbal, vitamins, homeopathic, complementary or similar types of remedies that you buy do you take most days?	

Think about your prescribed medicines only	Yes	No
Do you vary the way that you take your medicines?	☐	☐
Do you know what you take your medicines for?	☐	☐
Do you sometimes forget to take your medicines?	☐	☐

	Yes	No
Does anyone help you manage daily tasks (e.g. washing) who could give you more help managing your medicines?	☐	☐
Could the instructions on your medicines be improved to help you manage them better?	☐	☐
Do you think that some of your medicines could work better?	☐	☐

Additional information.

I agree for the doctor to review my need for a blister pack (monitored dosage system)

Patient's signature ……..……

Completed by…… Date……

Please return completed form to Dispensary