E.P.I.C.
Electronic Pharmacist Information Consultant
A Service of Pharma-Care, Inc. / Creative Care Consulting, LLC.

Pharma-Care, Inc.
Health Care Consultation Specialists
WWW.PHARMACAREINC.COM

Creative Care Consulting, LLC

FAX to : 732-574-3469 or 732-574-3926

MEDICATION REVIEW REQUEST

Date Transmitted_____

PLEASE PRINT CLEARLY

Facility: _____ **Unit:**_____

Resident Last Name: _____ **First Name:** _____

Doctor: _____ **Room Bed: #** _____ **Gender: M OR F** **Date of Birth** _____

Admission/Re-Admission Date: _____

Allergies:

SELECT ONE ONLY: **NEW, RE-ADMISSION** OR **CHANGE OF STATUS**

☐ **NEW ADMISSION** ☐ **POS ATTACHED**

Further Details:

☐ **RE-ADMISSION** ☐ **POS ATTACHED**

☐ **CHANGE OF STATUS REPORT** **"Please check event(s) to be evaluated in 'Change of Status' "**

- ☐ **ANOREXIA and/or Unplanned Weight Loss or Weight Gain**
- ☐ **Behavioral Changes, Unusual Behavior Patterns (Including Increased Distressed Behavior)**
- ☐ **Bleeding or Bruising, Spontaneous or Unexplained**
- ☐ **Bowel Dysfunction Including Diarrhea, Constipation and Impaction**
- ☐ **Dehydration, Fluid/Electrolyte Imbalance**
- ☐ **Depression, Mood Disturbance**
- ☐ **Dysphagia, Swallowing Difficulty**
- ☐ **Falls, Dizziness or Evidence of Impaired Coordination**
- ☐ **Gastrointestinal Bleeding**
- ☐ **Headaches, Muscle Pain, Generalized or Nonspecific Aching or Pain**
- ☐ **Mental Status Changes (e.g. New/Worsening Confusion, New Cognitive Decline, Worsening of Dementia (Including Delirium))**
- ☐ **Rash, Pruritus**
- ☐ **Respiratory Difficulty or Changes**
- ☐ **Sedation (Excessive), Insomnia or Sleep Disturbance**
- ☐ **Seizure Activity**
- ☐ **Urinary Retention or Incontinence**
- ☐ **OTHER:** _____

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Request Sent By _____ **Call Back Phone Number if Questions:** _____

FaxBack Number (IF DIFFERENT THAN CSID*) _____ **Number of Pages** (Plus this Cover Sheet) _____

* CSID IS THE FAX/PHONE NUMBER ENTERED INTO YOUR FAX MACHINE AS CLIENT IDENTIFICATION - ** ONE PATIENT PER TRANSMISSION *(DO NOT GANG OR GROUP RESIDENTS)*

NOTE: *COMPLETION OF THIS FORM INDICATES THAT THE FACILITY UNDERSTANDS THERE WILL BE A CHARGE FOR THIS REVIEW BASED ON ITS CURRENT CONTRACT*