

Best Possible Medication History (BPMH) CLARIFICATION Order Form

Affix Patient Label

**** THIS IS NOT A COMPLETE LIST OF
YOUR PATIENT'S HOME MEDICATIONS**
*PLEASE REFER TO THE BPMH***

Home Medication Clarification(s):				PRESCRIBER To Complete				MAR	
Medication Name <small>Include Prescription and regularly taken OTC, PRN, vitamin, herbal</small>	Dose	Route	Frequency	Continue	Discontinue	Hold	Change		Reason for Change/Hold/Discontinuation
Clarification required because medication was: <input type="checkbox"/> wrong dose/route/frequency <input type="checkbox"/> omitted <input type="checkbox"/> not taken at home									
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Clarification required because medication was: <input type="checkbox"/> wrong dose/route/frequency <input type="checkbox"/> omitted <input type="checkbox"/> not taken at home									
Comments/Notes:									
Source of Information: (at least two, one which includes the patient/caregiver): <input type="checkbox"/> Patient/caregiver recall <input type="checkbox"/> Medication vial(s)/blister pack <input type="checkbox"/> Discharge summary <input type="checkbox"/> MAR from another facility <input type="checkbox"/> Drug Profile Viewer <input type="checkbox"/> Family physician list <input type="checkbox"/> Medication list <input type="checkbox"/> Community pharmacy list									
Completed by (print): _____				Physician Name (print): _____					
Signature: _____				Signature: _____					
Date: _____ (ddmmyyyy) Time: _____ (hhmm)				Date: _____ (ddmmyyyy) Time: _____ (hhmm)					
If additional forms are required, please fill in, page ____ of ____ .									

Chart Copy – Do Not Destroy – Place in Physician Order Section

Scanned to Pharmacy: Yes or No

Date Scanned: _____ (dd/mm/yyyy)



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