

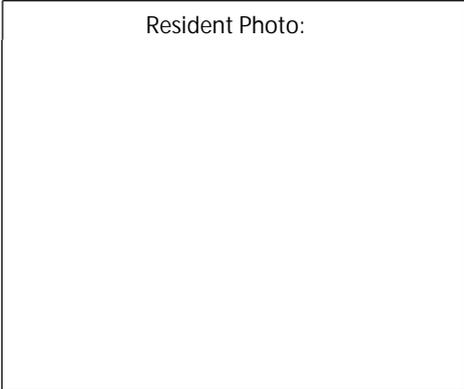
Test **Resident Overview Sheet to the Medication Chart**

Date first sent to pharmacy: _____

Care Home: Eventide Phone: 04 111 1111
 Address: one Beach St Fax: _____
Wellington Email: _____

Pharmacy: Pharmacy Partners **Doctor:** Dr Sidney Chambers
 Address: ARC Pharmacy Medical Centre: Care Services
1 Pharmacy St Address: 48 Bay St

Resident Details *(use label if available)*
 Family name: Test
 Given name: Theresa Preferred name: _____
 Date of Birth: 18/05/1926 NHI: ALM0425
 Gender: Female CSC: _____
 Area: _____ Room no. 1
 Height (cm): _____ Date: _____
 Weight: *Please see separate weight chart*



Allergies	
Record Medicine/Other reaction, cause and date of reaction if known, and initial.	Pharmacy notified
<u>p</u> Unable to determine	<u>p</u>
<u>p</u> No known allergies	<u>p</u>
<u>lat</u> latex	<u>y</u>
	<u>p</u>
	<u>p</u>
	<u>p</u>

Adverse Reactions	
Record Medicine reaction, cause and date reaction of if known, and initial.	Pharmacy notified
<u>p</u> Unable to determine	<u>p</u>
<u>p</u> No known reactions	<u>p</u>
<u>post</u> postural hypertension Calcium Channel Blockers	<u>y</u>
	<u>p</u>
	<u>p</u>
	<u>p</u>

The Resident Overview Sheet must accompany all communication to the pharmacy on resident admission and any changes to allergy or reaction information

Special Medication Considerations	
<u>p</u> Cognitive impairment	Other factors: _____
<u>p</u> Hepatic impairment	
<u>y</u> Renal impairment	
<u>y</u> Postural unsteadiness and/or falls risk	
<u>p</u> Swallowing difficulty	

Medication Review Completed		
Signature	Date	Notes for next visit/review

Sample signature record is maintained and held in (record physical location): _____