Interim Medication Regimen Review Request

Fax with MARS or POS

Check appropriate box below:

- ❑ ***Change of Condition review*** *needed (indicate condition below; If urgent, note below)*
- ❑ ***Short Stay*** *(<30 days) Resident review needed (i.e. prior to next routine consultant visit)*

To: Senior Care Consultant Group, LLC for _____ Pharmacy

Fax to: 888-311-0618

Facility's Name: _____ Nursing Unit:_____
Resident's Name: _____
Nurse's Name (Printed):_____ Nurse's Signature:_____
Nurse's Phone/Fax: _____
Date: _____ Pages (incl. cover page):_____

Resident's DOB: _____ **Physician Name**:_____

Allergies:_____

Place "X" in appropriate box
This resident's drugs will be crushed: ❑ Yes ❑ No
This resident has a history of falling: ❑ Yes ❑ No ❑ Unknown

Resident/Patient is experiencing the following condition(s):

- ❑ Anorexia and/or unplanned weight loss or weight gain.
  Specify the weight gain or weight loss = _____lbs loss or weight gain (circle one) over _____ time period
- ❑ Behavioral changes, unusual behavior patterns (increased distressed behavior)
  Describe behavior: _____
- ❑ Bowel function changes including constipation, ileus, impaction
- ❑ Confusion, cognitive decline, worsening of dementia (including delirium) of recent onset
- ❑ Dehydration, fluid/electrolyte imbalance – include BUN, SCr, electrolytes and date
- ❑ Depression, mood disturbance ❑ Dysphagia, swallowing difficulty ❑ Gastrointestinal Bleeding
- ❑ Excessive sedation, insomnia or sleep disturbance ❑ New Rash or pruritus
- ❑ Falls, dizziness, or evidence if impaired coordination - Specify ❑ New or ❑recurrent
- ❑ Headaches, muscle pain, generalized aching or pain ❑ New Seizure activity
- ❑ Spontaneous or unexplained bleeding, bruising- include INR, Hct, Hgb if available and date
- ❑ Unexplained decline in functional status (ADLs, vision). Describe:_____
- ❑ New or worsened urinary retention or incontinence ❑ Other specify:_____

****Attach most recent physician approved Physician Order Sheet and Current MAR, hospital transfer orders (form 3008, if appropriate), Diagnosis list, Labs if appropriate**

Fax any relevant information to assess change in condition. **Note:** A consultant pharmacist will respond to the Change of Condition and Short stay within 72 hours or 3 business days unless urgency indicated below:

- ❑ ***Urgent review needed:*** *Please provide a brief explanation of the nature of urgency. (i.e.: fall, allergic reaction, etc)*