

Pharmaceutical Care Plan (PCP)

Foundation Programme

PCP number:

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| --- | --- | --- | --- |
| **Date:** | **Patient initials:** | **Age:** (years) | **Male / female**  |
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| **Past Medical History****1**……….………………………………………………...........**2**……….………………………………………………...........**3**…………..…………………………..…………..……..…….**4**………...………………………………....…………….…….**5**………………………………….…………………………….**6**……..……………………………………………………....... |

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| **Allergies / Drug Sensitivities** |
| **Allergen/Drug (generic name)**Signature: | **Type of reaction (e.g. rash)**Date: |
| **No known allergies** | Signature:  | Date:  |
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| **Presenting complaint:** **Working diagnosis:**  |
|  |
| **Pre-admission medicines**(include GP, hospital and self medication) | **Continue** | **Hold** | **Stop** | **Change** | **Comments** | **Sources used:** |
|  |  |  |  |  |  | Patient |  |
|  |  |  |  |  |  | Relative/carer |  |
|  |  |  |  |  |  | NIECR |  |
|  |  |  |  |  |  | Comm pharmacy |  |
|  |  |  |  |  |  | GP surgery |  |
|  |  |  |  |  |  | GP letter |  |
|  |  |  |  |  |  | GP repeat list |  |
|  |  |  |  |  |  | Nursing home list |  |
|  |  |  |  |  |  | Residential home |  |
|  |  |  |  |  |  | PODs |  |
|  |  |  |  |  |  | Discharge Rx |  |
|  |  |  |  |  |  | Outpatient letter |  |
|  |  |  |  |  |  | Other (details) |  |
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| **Medicines started since admission** | **Date started** | **Comments** |
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| **Medication history confirmed: (signature)** |
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| **Relevant laboratory values** (consider trends) |  |
| **Date** →**Type** ↓ |  |  |  |  |  |  |  | **Reference range** |
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| **Cockcroft and Gault equation****Cr/Cl (in ml/min) = (140 – age (years)) x weight\* (in kg) x constant** *(\*see notes below regarding patient’s BMI)* **Serum creatinine (micromol/l)**(Where *constant* is *1.23* for men and *1.04* for women) **Patient Cr/Cl** (ml/min)…………… |
| **Relevant observations** (consider trends) |  |
| **Date** →**Type** ↓ |  |  |  |  |  |  |  | **Reference range** |
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| **Lifestyle issues** | **Height** …...…………..… **Weight** ………......................**BMI = weight (kg)/ height (m)2**

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| --- | --- |
| underweight | < 18.5 |
| ideal | 18.5 - 25 |
| overweight | 25 - 30 |
| obese | > 30 |

**Patient BMI** ……………………………………………… |
| **Smoking status:****Alcohol consumption:** |
| **Medicines management issues** |  |
| **Special requirements**Plain tops / Liquids Multicompartment aidWeekly dispensingLarge print / BrailleNon-English speakingLanguage:  | **Who is responsible for managing medicines**Patient / Spouse Relative / Carer Other | **Communication**Patient able to communicate effectively– yes/no | **Living arrangements**Lives aloneLives with familyNursing homeResidential homeSheltered accommodation |

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| **Pharmaceutical Care Plan** - in order of priority(NB refer to Pharmaceutical Care Plan Checklist for further information) |
|  | What are the **medication-related problems or risks?** | What are the **therapeutic goals?** (specify relevant guidelines, where applicable) | What are the **anticipated outcomes** and **monitoring requirements?**Is any **further action necessary?** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| 6. |  |  |  |
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| **FP pharmacist (name):** |