Date:

Recipient name:
Recipient Address:
Recipient Fax:

Patient Name:
Patient Address:
Patient Phone:
Date of Birth:
PHN:

Your patient, , has been having difficulty managing medications independently, and has agreed to receive assistance through the Medication Assistance Program (MAP) in which unregulated health care providers provide medication support.

To support your patient in receiving medication safely, please review the following:

☐ To receive medication assistance, this patient requires all regular oral medications to be packaged in a controlled dosage system (e.g., blister package, dosette, strip packaging), including over-the-counter (OTC) or herbal medications. Some manufacturer packaged unit dose medications may be left in original packaging as per pharmacist discretion.

☐ Please review and approve the use of OTC medication as requested by the care team.

☐ Reduce the number of medication administration times as much as possible. Patient assistance is provided in the morning, lunch, supper and/or bedtime based upon assessed need.

☐ Please collaborate with the health care team for medication reconciliation, annual medication reviews and monthly pharmacological restraint reviews (when prescribed).

☐ Please provide the following information to your patient's Case Manager and pharmacy provider:
a) Patient allergies (food, medication, etc.)
b) All new prescriptions, refills, or medication changes

☐ Please ensure all prescriptions include:
a) Start/stop dates
b) Indications for use
c) Specialized instructions (e.g. areas of application)

☐ If the patient requires medication assistance involving the use of medical sharps, then they will require safety engineered devices (SEDs) and sharps disposal containers. Please notify the pharmacy provider as soon as possible as these may have to be specially ordered.

Note: PRN medications will only be given via MAP under specific circumstances.
Please consult the Case Manager to discuss.

Please contact me with any questions or concerns.
Sincerely,

AHS Case Manager:
Email:
Phone:
Fax:

Patient's Pharmacy Provider:
Phone:
Fax: