



## Medication Review: Action Plan

Date of Review: \_\_\_\_\_

Pharmacist Name: \_\_\_\_\_

Doctor Name: \_\_\_\_\_

<i>Medication Use Issue</i>	<i>Proposed Action</i>	<i>Action by</i>	<i>Outcome, if known, with dates</i>

**Patient:**

- This is your copy; please retain it for your personal use. You may wish to share it with other health care professionals.
- Please make an appointment with your doctor to discuss within \_\_\_\_\_ weeks
- Take this form to your next scheduled doctor appointment
- Follow actions agreed to above

**Doctor:**

- This is your copy; please retain a copy in your patient's notes
- For information only – no action required
- Please review the actions proposed above