|  | ADULT FAMILY HOME’S (AFH) NAME | | | | | | LICENSE NUMBER | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PROVIDER / LICENSEE’S NAME | | | | | | INSPECTION DATE | |
| LICENSOR’S NAME | | | | | | | |
| ATTACHMENT L  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Resident Medication Review** | | | | | | | | |
| Each topic on this form covers a required area of the medication review. All sections must be completed for the review to be considered complete | | | | | | | | |
| 1. Does the home have a system in place to ensure each resident: 2. Has an assessment indicating the level of medication assistance needed by each resident? 3. Has a negotiated care plan identifying the medication service provided to that resident? 4. Has a medication log that is kept current? 5. Received medications as required; and 6. Has a current list of all prescribed and OTC medication in the resident’s record?  * Current list must include the name, dose, and frequency of the medication, as well as the name and phone number of the prescribing practitioner. | | | | | | | | |
| Yes  No; if no, explain why in the section below: | | | | | | | | |
|  | | | | | | | | |
| 1. Does the home have a system to address medication refusals? | | | | | | | | |
| Yes  No; if no, explain why in the section below: | | | | | | | | |
|  | | | | | | | | |
| 1. Are all medications appropriately identified, stored appropriately based on each medication’s requirements, and locked? | | | | | | | | |
| Yes  No; if no, explain why in the section below: | | | | | | | | |
|  | | | | | | | | |
| 1. Do all medications have an approved verification source?  * Approved verification sources include Pharmacy produced MAR, Physician’s Order, a written prescription, or a pharmacy produced medication label. * An AFH provider MAR is **not** an approved verification source. * Address electronic MARs (e-MARs) as you would a physical MAR. | | | | | | | | |
| Yes  No; if no, explain why in the section below: | | | | | | | | |
|  | | | | | | | | |
| Resident:  1  2 | | Resident Name: | | | | | | |
| 1. Were any psychopharmacologic medications identified?   Psychopharmacologic medications include **anti-depressants**, **anti-anxiety** (anxiolytics), **anti-psychotics,** and **mood stabilizers**. **Hypnotics** (sedative) are optional to include in the section. Include all medications in these categories, even if prescribed for an off-label use (reason unrelated to psychiatric diagnosis).   * If the reason for medications is unknown or unspecified, indicate this. | | | | | | | | |
| Yes  No If yes, complete the section below. | | | | | | | | |
| Medication Name | Verification Source (Check one applicable box for each medication.) | | | | | | | Reason for Medication |
|  | Pharmacy MAR / Label | | Physician’s Orders | Written Prescription | | No Approved Source | |  |
|  | Pharmacy MAR / Label | | Physician’s Orders | Written Prescription | | No Approved Source | |  |
|  | Pharmacy MAR / Label | | Physician’s Orders | Written Prescription | | No Approved Source | |  |
|  | Pharmacy MAR / Label | | Physician’s Orders | Written Prescription | | No Approved Source | |  |
|  | Pharmacy MAR / Label | | Physician’s Orders | Written Prescription | | No Approved Source | |  |
|  | Pharmacy MAR / Label | | Physician’s Orders | Written Prescription | | No Approved Source | |  |
| 1. If psychopharmacologic medications were identified, does the negotiated care plan include strategies and modifications to the environment to address the symptoms for this the medication is prescribed? | | | | | | | | |
| Yes  No If no, complete the section below. | | | | | N/A, no psychopharmacologic medications | | | |
|  | | | | | | | | |
| Resident:  1  2 | | Resident Name: | | | | | | |
| 1. Were any psychopharmacologic medications identified?   Psychopharmacologic medications include **anti-depressants**, **anti-anxiety** (anxiolytics), **anti-psychotics**, and **mood stabilizers**. **Hypnotics** (sedative) are optional to include in the section. Include all medications in these categories, even if prescribed for an off-label use (reason unrelated to psychiatric diagnosis).   * If the reason for medications is unknown or unspecified, indicate this. | | | | | | | | |
| Yes  No If yes, complete the section below. | | | | | | | | |
| Medication Name | Verification Source (Check one applicable box for each medication.) | | | | | | | Reason for Medication |
|  | Pharmacy MAR / Label | | Physician’s Orders | Written Prescription | | No Approved Source | |  |
|  | Pharmacy MAR / Label | | Physician’s Orders | Written Prescription | | No Approved Source | |  |
|  | Pharmacy MAR / Label | | Physician’s Orders | Written Prescription | | No Approved Source | |  |
|  | Pharmacy MAR / Label | | Physician’s Orders | Written Prescription | | No Approved Source | |  |
|  | Pharmacy MAR / Label | | Physician’s Orders | Written Prescription | | No Approved Source | |  |
|  | Pharmacy MAR / Label | | Physician’s Orders | Written Prescription | | No Approved Source | |  |
| 1. If psychopharmacologic medications were identified, does the negotiated care plan include strategies and modifications to the environment to address the symptoms for this the medication is prescribed? | | | | | | | | |
| Yes  No If no, complete the section below. | | | | | N/A, no psychopharmacologic medications | | | |
|  | | | | | | | | |
| Notes:  This section can be used to capture any additional information related to the review. Use of this section is optional. | | | | | | | | |