|  | ADULT FAMILY HOME’S (AFH) NAME | LICENSE NUMBER |
| --- | --- | --- |
| PROVIDER / LICENSEE’S NAME | INSPECTION DATE |
| LICENSOR’S NAME |
| ATTACHMENT LAGING 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. |