Home Medication Review (HMR) Referral Checklist

Medi Clarity
Bringing clarity to medication management

Patient Details	General Practitioner Details
Name:	Name:
Address:	Provider number:
Phone number:	Clinic name:
Date of birth:	Phone number:
Medicare number:	E-mail:
Language spoken:	Fax:

Reason for Referral (Tick all applicable)	✔
Polypharmacy	
Suspected non-adherence	
Recent hospital admission	
Poor health literacy	
Other (please specify):	

Patient Consent	✔
I have explained to the patient the process involved in having a HMR	
The patient understands that the location of the HMR is at own place of residence	
The patient understands that the pharmacist who will conduct the HMR will communicate with me information arising from the HMR	
The patient has consented to me releasing to the pharmacist information about their medical history and medications	
The patient consents to me releasing their Medicare/DVA Number details to the pharmacist for the pharmacist's payment purposes	

General Practitioner Signature	Date

Please attach patient's health summary, and any relevant clinic notes or pathology reports.

Please E-mail completed referral checklist to mediclarity.referrals@gmail.com.

Review will take place within two weeks of receipt of signed referral.