



Home Care Best Possible Medication History (BPMH) and Physician Confirmation Form

Return to Case Coordinator: _____

Phone #: _____

<p>To Prescriber: _____</p> <p>Phone #: _____</p> <p>Fax #: _____</p> <p><input type="checkbox"/> Faxed Initials: _____ Date/Time: _____</p> <p style="text-align: center;">Or</p> <p><input type="checkbox"/> Original Sent to Prescriber</p>	<p>Re: Client</p> <p>Name: _____</p> <p>Address: _____</p> <p>PHIN: _____ Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes (Specify Below)</p> <p>_____</p> <p>_____</p>
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<p>According to our records this client currently receives the following medications/treatments. Please complete the Prescriber Review & Order Section and sign when complete. Thank you for your anticipated cooperation.</p> <p>Current Orders (Medication, Dose, Route, Frequency): _____</p>	<p>Information Source(s):</p> <p><input type="checkbox"/> DPIN</p> <p><input type="checkbox"/> Community Pharmacy</p> <p><input type="checkbox"/> Patient/Caregiver</p> <p><input type="checkbox"/> Other _____</p>	<p>Prescriber Review & Order</p> <p>Review each medication & check off appropriate box</p> <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width:10%;">Con- tinue</th> <th style="width:10%;">Do Not Order</th> <th style="width:10%;">Change (see last column)</th> <th style="width:70%;">Change to Med/Treatment and Reason <small>**Note: This is not a prescription; a separate prescription must be given for any changes to current orders.</small></th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> </tbody> </table>	Con- tinue	Do Not Order	Change (see last column)	Change to Med/Treatment and Reason <small>**Note: This is not a prescription; a separate prescription must be given for any changes to current orders.</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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Prescriber Signature: _____	Date: _____	Time: _____
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Please Return to FAX #: _____ *Response by telephone or fax may be billed under Tariff 8000.*

History Completed By: _____ **Signature:** _____

White Copy: To Prescriber Yellow Copy: Nursing Chart Page ____ of ____

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