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

Return to Case Coordinator: _____

Phone #: _____

To Prescriber: _____

Phone #: _____

Fax #: _____

☐ **Faxed** **Initials:** _____ **Date/Time:** _____

Or

☐ **Original Sent to Prescriber**

Re: Client

Name: _____

Address: _____

PHIN: _____ **Allergies:** ☐ No ☐ Yes (Specify Below)

_____

_____

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.

Information Source(s):
☐ DPIN
☐ Community Pharmacy
☐ Patient/Caregiver
☐ Other _____

Current Orders (Medication, Dose, Route, Frequency):

Prescriber Review & Order
Review each medication & check off appropriate box

Current Orders (Medication, Dose, Route, Frequency):	Continue	Do Not Order	Change (see last column)	Change to Med/Treatment and Reason **Note: This is not a prescription; a separate prescription must be given for any changes to current orders.
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Prescriber Signature: _____ **Date:** _____ **Time:** _____

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** ____