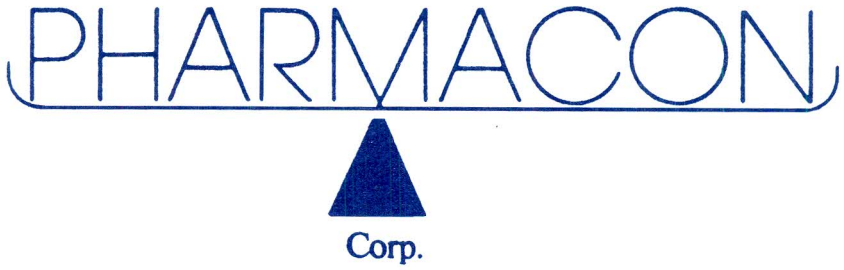
RICHARD A. ZELKOWITZ
PRESIDENT
Cell (917) 834-7220



Pharmaceutical Consultants to Health Care Institutions

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Interim Medication Regimen Review (iMRR) and Important Points to Consider

One provision of the new guidance requires the facility to ensure that the pharmacist, facility and medical director collaborate to "establish procedures that address medication regimen reviews (MRRs) for residents who are anticipated to stay less than 30 days or when the resident experiences an acute change of condition as identified by facility staff."

To address these regulatory changes, Pharmacon implemented a process to address interim reviews. Facility will complete a "Request for Medication Regimen Review" Form and fax it to the number printed on the form.

Key Points:

Please complete all demographic information at top of form.

1) Short Stay:

   a. Upon admission, determine is the resident's Length of Stay is predicted to be less than 30 days
   b. If so, request an interim Medication Regimen Review (iMRR), using the "Request for Medication Regimen Review" Form.
   c. An interim review does not need to be done if the resident's stay is anticipated to be long term.
   d. Include copy of current Medication Administration Record and any pertinent laboratory data and consults.

2) Change of Condition:

   a. Refer to "Request for Medication Regimen Review" Form for symptoms, signs, and conditions that may be associated with medications.
   b. Check the applicable symptom(s), sign(s) or condition(s) that apply for the resident. Please clarify as to what the change of condition is (e.g. weight loss/weight gain—make sure you specify which one)
   c. Include copy of current Medication Administration Record and any pertinent laboratory data and consults.

It is recommended that your facility procedures include a review of each Medication Regimen Review Request by selected facility staff (e.g. DON, MDS Coordinator) before these forms are faxed to the pharmacy to ensure appropriate use of this process.

17 Longview Drive • Eastchester N.Y. 10709 • (914) 961-3372 • FAX (914) 961-3374

Request for Medication Regimen Review

Resident: _____ RM: _____ DOB:_____ Date of Request: _____

Nurse completing form (please print): _____ Physician:_____

Facility Name: _____ Phone: _____

Fax back to (name): _____Fax Number: _____

Please check the box that applies.

Length of Stay

☐ The resident is anticipated to stay less than 30 days and a pharmacist Medication Regimen Review is requested.

Symptoms, Signs and Conditions that May be Associated with Medications[1]

The Resident has recently experienced, or currently has signs and symptoms of, one or more of the following conditions and a pharmacist Medication Regimen Review is requested. Please check all that apply.

Check off box & circle specific condition

- ☐ Anorexia and/or unplanned weight loss, or weight gain
- ☐ Behavioral changes, unusual behavior patterns (including increased distressed behavior)
- ☐ Bleeding or bruising, spontaneous or unexplained
- ☐ Bowel dysfunction including diarrhea, constipation and impaction
- ☐ Dehydration, fluid/electrolyte imbalance
- ☐ Depression, mood disturbance
- ☐ Dysphagia, swallowing difficulty
- ☐ Falls, dizziness, or evidence of impaired coordination
- ☐ Gastrointestinal bleeding
- ☐ Headaches, muscle pain, generalized or nonspecific aching or pain
- ☐ Mental status changes (e.g., new or worsening confusion, new cognitive decline, worsening of dementia (including delirium))
- ☐ Rash, pruritus
- ☐ Respiratory difficulty or changes
- ☐ Sedation (excessive), insomnia, or sleep disturbance
- ☐ Seizure activity
- ☐ Urinary retention or incontinence
- ☐ Other _____

_____

[1]Investigative Protocol, §483.25(l)(1) Unnecessary Drugs

List medications below or provide copy of current physician order sheet or medication administration record:

_____

_____

_____

Provide all recent (within last 14 days) laboratory reports and related consults.

PLEASE FAX to: 718 380-4107

FOR PHARMACON USE ONLY

Pharmacist Completing Medication Assessment: _____**Date Faxed:**_____