London Health Sciences Centre

INTEGRATED BEST POSSIBLE MEDICATION HISTORY (BPMH) AND RECONCILED ADMISSION & DISCHARGE MEDICATION ORDERS

- **USE BALL POINT PEN, PRESS FIRMLY**

ACCEPTABLE ABBREVIATIONS

DO NOT USE	USE	DO NOT USE	USE	DO NOT USE	USE
U, IU, u QD, QD or qd QOD or qod drug name abbreviations	unit daily every other day write generic drug name	D/C cc µg @	discharge or discontinue mL mcg at	> or < trailing zero (x.0 mg) lack of leading zero (.x mg) OS, OD, OU	greater than or less than never use zeros **after** decimal always use zeros **before** decimal left eye, right eye, both eyes

BEST POSSIBLE MEDICATION HISTORY (BPMH)

SOURCE OF HOME MEDICATION HISTORY

- ☐ Family Doctor: _____
- ☐ Specialist: _____
- ☐ Community Pharmacy: _____
- ☐ Other: _____
- ☐ Medication Administration Record from prior institution
- ☐ Ontario Drug Benefit Drug Profile Viewer
- ☐ Patient recall
- ☐ Discharge note/clinic visit
- ☐ Medication vials/containers
- ☐ Family

RECONCILED ADMISSION / DISCHARGE MEDICATION ORDERS

Patient weight _____ kg and height _____ cm

ACTUAL or ESTIMATE (circle one)

Specify changes to HOME medications ONLY in section below.

(e.g. decrease atenolol to 12.5 mg once daily due to low BP)

HOME MEDICATION	DOSE	ROUTE	FREQUENCY	INIT.	Reconciled Inpatient Medication Orders AT ADMISSION (✓) CONTINUE	MODIFY	HOLD	DISCONTINUE	MEDICATION CHANGES & RATIONALE	P	Discharge Medication Plan AT DISCHARGE (✓) NO PRESCRIPTION	CONTINUE	HOLD	MODIFY (See below)	DISCONTINUE
					☐	☐	☐	☐							
					☐	☐	☐	☐							
					☐	☐	☐	☐							
					☐	☐	☐	☐							
					☐	☐	☐	☐							
					☐	☐	☐	☐							

INITIAL HISTORY OBTAINED BY: **Name/Signature/Designation:**	**DATE (YYYY/MM/DD):**	**TIME:**	**PROCESSOR'S INITIALS:**	**DATE (YYYY/MM/DD):**	**TIME:**
ADDITIONAL HISTORY INFORMATION OBTAINED BY: **Name/Signature/Designation:**	**DATE (YYYY/MM/DD):**	**TIME:**	**NURSE INITIALS:**	**DATE (YYYY/MM/DD):**	**TIME:**
ADDITIONAL HISTORY INFORMATION OBTAINED BY: **Name/Signature/Designation:**	**DATE (YYYY/MM/DD):**	**TIME:**	**COPY HAS BEEN SENT TO PHARMACY:** **Initials:**	**DATE (YYYY/MM/DD):**	**TIME:**
PRESCRIBER'S PRINTED NAME / COLLEGE OR MEDICAL DIRECTIVE # / SIGNATURE / DESIGNATION / CONTACT #:				**DATE (YYYY/MM/DD):**	**TIME:**

- DO NOT THIN FROM CHART -

LONDON HEALTH SCIENCES CENTRE DISCHARGE PRESCRIPTION(S)

PATIENT INSTRUCTIONS: This is a Prescription, give to your Community Pharmacist.

DATE (YYYY/MM/DD): _____

- ☐ **No Changes to Home Medications at Discharge**
- ☐ **New Prescriptions:**

PATIENT'S NAME: **HC #:**

ADDRESS:

	MEDICATION	DOSE	ROUTE	FREQUENCY	DIRECTIONS	QUANTITY	REFILLS
1.							
2.							
3.							
4.							
5.							

PRINT NAME OF PHYSICIAN: _____ PHYSICIAN'S SIGNATURE: _____ CPSO#/CDSO#: _____

London Health Sciences Centre

INTEGRATED

BEST POSSIBLE MEDICATION HISTORY (BPMH) TO BE USED WITH TRANSFER, POST-OPERTIVE AND DISCHARGE RECONCILIATION

- **USE BALL POINT PEN, PRESS FIRMLY**

ACCEPTABLE ABBREVIATIONS

DO NOT USE	USE	DO NOT USE	USE	DO NOT USE	USE
U, IU, u QD, QD or qd QOD or qod drug name abbreviations	unit daily every other day write generic drug name	D/C cc µg @	discharge or discontinue mL mcg at	> or < trailing zero (x.0 mg) lack of leading zero (.x mg) OS, OD, OU	greater than or less than never use zeros **after** decimal always use zeros **before** decimal left eye, right eye, both eyes

BEST POSSIBLE MEDICATION HISTORY (BPMH)

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- ☐ Discharge note/clinic visit
- ☐ Medication vials/containers
- ☐ Family

HOME MEDICATION	DOSE	ROUTE	FREQUENCY	INIT.

RECONCILED ADMISSION / DISCHARGE MEDICATION ORDERS

Patient weight _____ kg and height _____ cm

ACTUAL or ESTIMATE (circle one)

DOCUMENT COMMENTS AND/OR FOLLOW-UP ACTIONS FOR NEWLY REPORTED HOME MEDICATIONS (Post-Admission)

(e.g. discovered phenytoin 3rd day, Dr. notified, order received)

DETAIL ACTIONS TAKEN	INITIAL & DATE	Discharge Medication Plan AT DISCHARGE (✓) NO PRESCRIPTION	CONTINUE	HOLD	MODIFY (See below)	DISCONTINUE

INITIAL HISTORY OBTAINED BY: **Name/Signature/Designation:**	**DATE (YYYY/MM/DD):**	**TIME:**
ADDITIONAL HISTORY INFORMATION OBTAINED BY: **Name/Signature/Designation:**	**DATE (YYYY/MM/DD):**	**TIME:**
ADDITIONAL HISTORY INFORMATION OBTAINED BY: **Name/Signature/Designation:**	**DATE (YYYY/MM/DD):**	**TIME:**

BPMH REVIEWED WITHIN 24 HOURS BY: **Name/Signature/Designation:**	**DATE (YYYY/MM/DD):**	**TIME:**

LONDON HEALTH SCIENCES CENTRE DISCHARGE PRESCRIPTION(S)

COPY

DATE (YYYY/MM/DD): _____

- ☐ **No Changes to Home Medications at Discharge**
- ☐ **New Prescriptions:**

PATIENT'S NAME: **HC #:**

ADDRESS:

	MEDICATION	DOSE	ROUTE	FREQUENCY	DIRECTIONS	QUANTITY	REFILLS
1.							
2.							
3.							
4.							
5.							

PRINT NAME OF PHYSICIAN: _____ PHYSICIAN'S SIGNATURE: _____ CPSO#/CDSO#: _____

DISTRIBUTION: Page 1 (White) - Copy to Inpatient Pharmacy, Patient Care Order section. At discharge detach Discharge Prescription and give to Patient if applicable Page 2 (Blue) - Protector in front of Patient Care Order section

THE PURPOSE OF THIS MULTIDISCIPLINARY FORM IS TO:

- Ensure the BPMH is obtained, documented and maintained on this form only and then filed in one place in the patient chart (Patient Care Order section)
- Document reconciliation of home medications with Admission Medication Orders and to document reconciliation of home medications at discharge
- Allow the Prescriber to review the BPMH prior to writing Medication Orders at all transition points throughout the patient's stay (Admission, Transfer and Discharge)
- Allow the prescriber to write out prescriptions at discharge (bottom section of form), when necessary

MEDICATION RECONCILIATION STANDARD PRACTICE

- Medication Reconciliation is a shared responsibility between Medical Staff, Nursing and Pharmacy
- All admitted patients (> 24 hours) will have a completed BPMH prior to Admission Medication Orders being written

INITIATION OF THE RECORD:

- Initiated by the first Regulated Health Professional assessing and documenting the patient's medication history
- Completion of this BPMH meets the requirement for documentation of the patient's medication history
- To avoid duplication or confusion, the person completing this form then writes "See BPMH" on other documents where medication history may have been previously recorded

COMPLETING THE FORM

PAGE 1: INTEGRATED BEST POSSIBLE MEDICATION HISTORY (BPMH) and RECONCILED ADMISSION & DISCHARGE MEDICATION ORDERS

- Complete BPMH on left side of form including: all prescription medications, over-the-counter (OTC) medications, herbal preparations, supplements (e.g. vitamins, minerals)
- When documenting multiple medications, initial beside the first medication, arrow down to the last entry and initial beside the last medication
- Sign and date "Initial History Obtained By" box
- Prescriber/Delegate to reconcile all home medications and write Reconciled Inpatient Medication orders using the columns provided (Continue, Modify, Hold or Discontinue)
- Modifications to home medications and rationale for the changes must be documented in the "Medication Changes and Rationale" section (middle)
- Prescriber to use right hand side of form to document Discharge Medication Plan (i.e. reconciliation of home medications for discharge purposes).
- Prescriber to print name, sign and date in "Prescriber" box
- Processor of Orders must photocopy this form, once completed by Prescriber, send the copy to Pharmacy and sign off in the designated box.
- Processor will check off under "P" as each order is processed onto the Medication Administration Record. Nurse will initial in designated box once orders have been verified as with all other patient care orders.
- The bottom section of the form is a Discharge Prescription. If there are no changes to home medications at discharge, the prescriber is to indicate this using the appropriate checkbox. The Prescriber will then fill out the required sections of the prescription and write out any new medications (or modifications of home medications) that require new prescriptions at discharge.
- At discharge, the bottom portion of the form is detached (at the perforation) and the original copy is given to the patient (the blue copy will stay in the chart for documentation purposes).
- PLEASE NOTE: At discharge, if there are **no** changes to home medications (use the appropriate checkbox) and the patient **does not** require any new prescriptions, this part of the form is kept intact in the chart.

PAGE 2: BEST POSSIBLE MEDICATION HISTORY (BPMH) – Blue copy of Form
(To be placed in page protector in Orders section of chart)

- The BPMH is reviewed within 24 hours post admission by the nurse and signed off in box provided
- To change an entry on the BPMH – draw a single straight line through the original entry and initial. Add the corrected information on the next available line, and initial in the column to the right of your entry.
- To add information about home medications after the Admission Orders have been processed, document the information on the next available line on the left side of page, and initial in the column to the right of your entry. Add "Prescriber notified" and any actions taken to reconcile any new home medication information in the section titled "Document Comments and/or Follow-Up Actions". Then initial and date in the column to the right of your entry. Sign the "Additional History Information Obtained By" box.