Good Practice Guidance for Care Homes
Clinical Consultation Prescribing Checklist

The purpose of this form is to ensure that the care home have an accurate record of a prescriber’s intentions when a resident is accompanied to a medical appointment, where a medication is started, stopped or the instructions are changed. Completion of this form will ensure the care home has the necessary information for the resident to gain the maximum benefit from the medication and minimise the risk of any necessary monitoring being missed. The MAR records must be available to the clinician at the time of the consultation.

<table>
<thead>
<tr>
<th>Resident Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carer completing the form:</td>
<td>Date:</td>
</tr>
<tr>
<td>Clinician Name:</td>
<td>Service:</td>
</tr>
<tr>
<td>No. of days left in current cycle:</td>
<td></td>
</tr>
</tbody>
</table>

Appointment Information
- Place (address)
- Time
- Transport by
- Name of person accompanying
- Relationship of accompanying person

Outcome of appointment
- Give details of any medication prescribed, what is it for, and how long is it expected to be needed for?
- If the medicine is variable dose or PRN, what is the indication, when should each dose be used and what should prompt a review?
- What monitoring required?
- Time scale for future appointment/review?
- Mechanism for future supply?