



Good Practice Guidance for Care Homes
Clinical Visit / Appointment Outcome Form

The purpose of this form is to ensure that the care home have an accurate record of a prescriber's intentions when a person 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 person 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.

Persons Name:		Date of Birth:	
Person completing the form:		Service:	
Clinician Name:		Date & time of appointment:	

Outcome of appointment
Give details of any medication newly 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?
Give details of any changes to existing medication – dose or frequency increase / decrease, or medication stopped.
What monitoring is required?
Time scale for future appointment/review?
Mechanism for future supply?

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