AQPP
ASSOCIATION QUÉBÉCOISE
DES PHARMACIENS PROPRIÉTAIRES

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Traduction

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THERAPEUTIC EVALUATION

Consultation date: _____/_____/20 _____

Name of patient: _____

During your meeting with your pharmacist, you reviewed all the drugs you are taking. You provided your pharmacist with information that helped clarify your drug treatments.

Action Plan
in Partnership with Your Pharmacist

Following an analysis of **your** situation, your pharmacist is suggesting certain actions that you both already agreed on.

STEPS THAT YOU CAN TAKE IMMEDIATELY	
Stop taking:	
Change the dosage of:	
Take this medication at a different time:	
Take the following medication:	
Lifestyle changes to make:	

We will be making some recommendations to your physician to improve the efficacy or comfort of your treatment or to make it easier for you to take.

WE WILL CONTACT YOUR PHYSICIAN ABOUT THE FOLLOWING:	
Medications to be changed or stopped:	
Dosage to be modified:	
Proposed new medications:	
Other measures:	

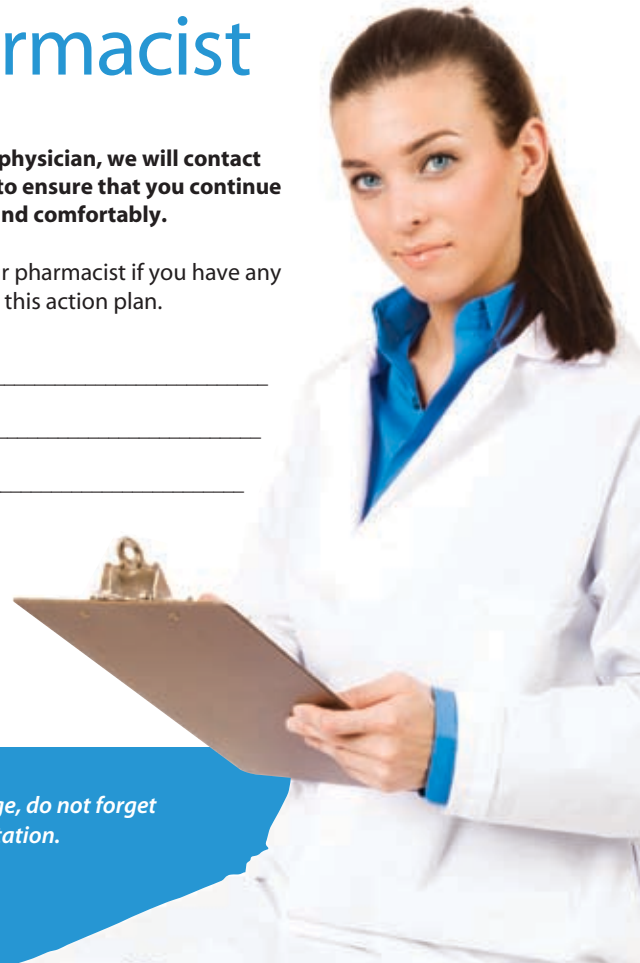
Following our discussion with your physician, we will contact you with the instructions you need to ensure that you continue to take your medications properly and comfortably.

Please do not hesitate to contact your pharmacist if you have any questions about your medications or this action plan.

Your pharmacist: _____

Phone number: _____

Signature: _____



If you have private insurance coverage, do not forget to submit your receipt for this consultation.