

Patient:				GP:			
<input type="checkbox"/> For information only – no action required <input type="checkbox"/> Follow your actions agreed below <input type="checkbox"/> Please note the recommendations made to your GP This is your copy of the form. You may wish to show it to other health care professionals.				<input type="checkbox"/> For information only – no action required <input type="checkbox"/> Please consider the recommendations proposed below A copy of the consultation record sheet can be obtained from the pharmacy if required. Clinical codes: Medicines Use Review done by community pharmacist: 4byte:8BMF Version 2:8BMF. Clinical Terms Version 3:xaKuo SNOMED CT:198391000000102			
Patient details				GP details			
Title:		First Name:		Surname:		GP Name:	
NHS Number:			Tel:	Date of Birth:		Practice Name:	
Address:				Address:			
Name of other people present			Consent for MUR obtained: Oral <input type="checkbox"/> Written <input type="checkbox"/>		Date of review:		
Review type: Annual MUR <input type="checkbox"/> Intervention MUR <input type="checkbox"/>		Review identified or requested by: Pharmacist <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Location of review if not in pharmacy:		PCO permission granted for off-site MUR: Yes <input type="checkbox"/>	
Action plan							
Issue		Recommendation				For consideration by:	
						<input type="checkbox"/> Patient <input type="checkbox"/> Pharmacist <input type="checkbox"/> GP <input type="checkbox"/> Other:	
						<input type="checkbox"/> Patient <input type="checkbox"/> Pharmacist <input type="checkbox"/> GP <input type="checkbox"/> Other:	
						<input type="checkbox"/> Patient <input type="checkbox"/> Pharmacist <input type="checkbox"/> GP <input type="checkbox"/> Other:	
						<input type="checkbox"/> Patient <input type="checkbox"/> Pharmacist <input type="checkbox"/> GP <input type="checkbox"/> Other:	
Pharmacy details							
Pharmacist Name:		Pharmacist registration no.:		Pharmacy Name:		Tel:	Email address:
Address:							

Title:		First name:		Surname:		NHS Number:		Date of birth:		Date of review:	
Current Medicines (including over the counter & complementary therapies)		Does the patient use the medicine as prescribed?	Does the patient know why they are using the medicine?		More info provided on use of medicine		Is the formulation appropriate?		Are side effects reported by the patient?		General comments relating to advice, side effects and other issues
1	Name/Dosage form/Strength:	<input type="checkbox"/> Yes If no, specify:	Yes	No	Yes	No	Yes	No	Yes	No	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Dose:										
2	Name/Dosage form/Strength:	<input type="checkbox"/> Yes If no, specify:	Yes	No	Yes	No	Yes	No	Yes	No	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Dose:										
3	Name/Dosage form/Strength:	<input type="checkbox"/> Yes If no, specify:	Yes	No	Yes	No	Yes	No	Yes	No	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Dose:										
4	Name/Dosage form/Strength:	<input type="checkbox"/> Yes If no, specify:	Yes	No	Yes	No	Yes	No	Yes	No	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Dose:										
5	Name/Dosage form/Strength:	<input type="checkbox"/> Yes If no, specify:	Yes	No	Yes	No	Yes	No	Yes	No	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Dose:										
6	Name/Dosage form/Strength:	<input type="checkbox"/> Yes If no, specify:	Yes	No	Yes	No	Yes	No	Yes	No	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Dose:										