**Additional file 1:** Medication reconciliation form.

**MEDICATION RECONCILIATION FORM**  Date: \_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_

Patient code number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Admission diagnosis (e.g. triage form): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Weight: \_\_\_\_\_kg, Height: \_\_\_\_\_\_cm, Plasma creatinine: \_\_\_\_\_\_\_\_(date), RR and pulse \_\_\_\_\_\_\_\_\_\_(date)

Other relevant laboratory results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recent diet changes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoking: no \_\_\_yes \_\_\_\_ \_\_\_\_cigarettes/day Alcohol use: no \_\_\_yes \_\_\_\_ \_\_\_\_\_ doses/week

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| **Patient’s medications:** |
| 1Prescription (R), OTC (I)2Patient chart (SK), Medication card (L), Interview (H), Prescriptions (R), Dose dispensing (A), Hospice care (HP), Electronic archives (E), Relative (O), Other (M)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3Long-term (S) and PRN, pro re nata = as needed (T) |
| Drug, strength and formulation (R/I1) | Reference (code2) | Dosing(eg. 1 tbl x 3) | Dosing times | S/T3 | Comments, and if needed the indication for the medication |
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**Check-list for medication reconciliation:** Does patient use:

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| --- | --- | --- |
| medications that affect blood clotting\_\_\_ | heartburn medication\_\_\_ | medication for constipation\_\_\_ |
| medication for flu\_\_\_ | pain killers\_\_\_ | medicinal cream\_\_\_ |
| allergy medication \_\_\_ | vitamins\_\_\_ | injectable medication (insulin etc.)\_\_\_ |
| cough medicine\_\_\_ | herbal product \_\_\_ | eye medication (drops)\_\_\_ |
| 1x/week or 1x/month etc. administrated medications\_\_\_ | medical patches (nicotine, nitro, hormone, dementia)\_\_\_ | aerosols (asthma, nitro etc.) \_\_\_ drugs that belong to someone else \_\_\_ |

Have your medications been altered during the last month? No \_\_\_ Yes \_\_\_, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication administration and adherence outside of the hospital**

Do you take your medications according to your medication plan? Yes \_\_\_ No \_\_\_

Have you made changes to your medications? Yes \_\_\_ No \_\_\_

Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Possible problems (fill in the comment section of the patient’s medication list):** |
| Problems in swallowing \_\_\_ | Difficulties with administration \_\_\_  |
| Medication costs \_\_\_ | Inefficacy or excessive efficacy \_\_\_ |
| Side effects \_\_\_ | Missing or unclear instructions \_\_\_ |
| Fear \_\_\_ | Inappropriate use of OTC medications \_\_\_  |
| Dementia \_\_\_ | Several caregivers, unclear responsibility \_\_\_ |
| Difficult dispensing (e.g. package opening)\_\_\_\_  | Other, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
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 **Check-list for the detection of side effects:**

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| --- | --- | --- | --- | --- |
| Acid reflux \_\_\_  | Nausea \_\_\_  | Dry mouth \_\_\_  | Diarrhoea \_\_\_  | Constipation \_\_\_ |
| Pain \_\_\_ | Sweating \_\_\_  | Dysuria \_\_\_  | Itching\_\_\_  | Amnesia \_\_\_ |
| Stiffness \_\_\_ | Falls \_\_\_  | Dyspnoea\_\_\_  | Chest pain\_\_\_  | Arrhythmias \_\_\_ |
| Dizziness \_\_\_  | Walking difficulties \_\_\_ | Insomnia \_\_\_  | Anxiety \_\_\_  | Confusion \_\_\_ |
| Swelling \_\_\_  | Cough \_\_\_  | Visual disturbances \_\_\_ | Restless legs, cramps, leg pain \_\_\_  |

Description:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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When did you last take your medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any medication with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interviewers comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Additional information:

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Interviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional file 2:** Medication review form

**MEDICATION REVIEW FORM**

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| --- |
|  **Patient code number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** * GFR (CKD-EPI): \_\_\_\_\_\_\_ ml/min.
* Admission diagnosis:
* Detected adverse drug reactions in the patient interview:
 |

**DRUG-RELATED PROBLEMS:**

|  |  |
| --- | --- |
| **1. Adverse drug reactions**1,2 |  |
| **2. Overlapping medications**2,3  |  |
| **3. Clinically problematic interactions2**-5  |  |
| **4. Dose (including inappropriate doses with renal insufficiency)**2,6  |  |
| **5. Dosing schedule**2,7 |  |
| **6. Missing medications compared to diagnoses**2,8 |  |
| **7. Potentially inappropriate medications for older patients (≥75 years)**9 |  |
| **8. Problems with adherence**1 |  |
| **9. High-alert medications**10-11  |  |
| **10. Other important findings**(e.g. need for monitoring, inappropriateness of the hospital drugs with home medication, costs and reimbursement aspects, availability, dosing technique, length of treatment, no indication) |  |

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| **SUMMARY OF THE FINDINGS FOR THE PHYSICIAN** **(documented and sent to the patient information system):**1. **Drug-related problems certainly or probably linked to admission diagnoses:**
2. **Other acute drug-related problems (needing actions in the emergency department):**
3. **Drug-related, non-acute problems (needing actions later after discharge):**
 |

|  |
| --- |
| **Date, completed by:**  |
| **Summary delivered to physician (date and physician):**  |

**References**

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