Medication Reconciliation at Discharge & Transfer in Acute Care - Frequently Asked Questions

The frequently asked questions (FAQs) listed below were developed to support the use of medication reconciliation (MedRec) form for discharge and transfer in the acute care inpatient setting. The form referred to is the Saskatchewan Discharge/Transfer MedRec (DTMR) Form. There are currently two versions of the DTMR Form:

- The computer generated form (used in facilities with electronic access).
- The paper-based form (used when there is no access to pharmacy or no electronic capacity in the facility).

If you have any questions or comments about the FAQs, contact your area's MedRec lead or the Patient Safety Unit at the Ministry of Health (PatientSafety@health.gov.sk.ca).

Topics:

Discharge/Transfer MedRec (DTMR) Form Basics

1. When should medication reconciliation take place?

AT DISCHARGE: This is the movement of an acute care patient:
- to their home, whether that home is in the community, a personal care home or a long-term care facility; or
- to a supportive care bed (e.g., palliative care, respite).

AT EXTERNAL TRANSFER: This is the movement of an acute care patient between two acute care inpatient facilities.

Documentation required: A set of transfer documentation is required. Whenever possible, the sending site should complete reconciliation prior to the patient transfer using the DTMR Form to create an external transfer medication list.

The following medication documentation should accompany the patient:
I.   External transfer medication list (DTMR Form),
II. Best possible medication history (i.e., Pharmaceutical Information Program (PIP) MedRec form completed through a patient interview by the first facility to receive the patient during the hospital episode),
III. Most recent 24-72 hours of the medication administration record (MAR), and
IV. Most recent 72-hours prescriber order sheets.

When a patient is decompensating rapidly and time does not allow for medication reconciliation, at a minimum the following documents should accompany the patient in order for MedRec at admission to be completed by the receiving site:
I.   Best possible medication history (i.e., Preadmission Medication List / Prescriber Order Form completed through interview by the first facility to receive the patient during the hospital episode),
II. Most recent 72 hours of the MAR, and
III. Most recent 72-hour prescriber/physician order sheets.

See Appendices for samples of completed DTMR Forms at discharge and external transfer.

2. Under what circumstances can the DTMR Form be used as an admitting order?

The DTMR Form can be used as an admitting order when a physician has admitting privileges and when a patient:
a) Is discharged from an acute care facility to a personal care home, a long-term care facility or a supportive care bed (e.g., palliative care, respite).
b) Is an internal or external transfer from:
- a higher level of acute care to a lower level of acute care, or vice versa (see Q3).

3. How is medication reconciliation completed on external transfer?

The DTMR Form may be used to generate an external transfer medication list when the transfer is occurring from a higher level of acute care to a lower level. In situations like this, the "Continue" and "STOP" columns under "Prescriber Orders" need to be completed. Quantity and refills are not applicable. Identify as admitting orders on the DTMR.

If the transfer is occurring from a lower level of acute care to a higher level of acute care, the medication reconciliation will be happening at the *receiving site*, regardless of whether it is done as MedRec at admission/transfer. In these situations, area procedures will apply. If the DTMR Form is used at the *sending facility* as the transfer medication list, the columns beneath "Prescriber Orders" are to remain blank. This is because under most circumstances, a sending facility prescriber cannot write orders for a receiving facility. The DTMR Form will be completed by the *prescriber in the receiving site* as admitting orders per area specific procedures. Identify these are the admitting orders on the DTMR Form.

If the sending site sends a copy of the DTMR Form as the transfer medication list, it can be used at the receiving site to complete as admitting orders to reduce the risk of transcription errors and increase patient safety. The original DTMR with the transfer medication list will be kept in the patient file at the sending site. The DTMR that is completed by the receiving site as prescriber orders on admission now becomes the current orders based on the *chronological sequence of events for patient care* and will be placed in the medication orders section of the patient chart.

With regard to the documentation of discrepancy identification and resolution:
- If there are no discrepancies, whoever is completing the external transfer medication list will sign and date on the "Reviewed by" line.
- If there are discrepancies, they are noted on the DTMR Form using the "Comments/Rationale/Indication" column, and a prescriber is asked to resolve the differences noted. When the discrepancies are resolved, the prescriber will sign and date on the "Reviewed by" line.
- If there are discrepancies but time does not allow for a physician to resolve the discrepancy, the discrepancy should be described using the **"Other Medication Instructions/Comments" box** on the last page and flagged to indicate that the discrepancy was not resolved prior to transfer. The person completing and identifying discrepancies signs on the "Reviewed by" line.

4. Why do we have to send an external transfer medication list (DTMR Form) with the MAR? Can't we just send the MAR?

The external transfer medication list is a communication tool that summarizes the patient's medication management in relation to the Best Possible Medication History (BPMH) collected by the sending facility on the Preadmission Medication List / Prescriber Order Form (also known as the PIP).

For example, it can include information such as medications stopped at admission and the rationale for stopping these meds (such as an automatic therapeutic substitution, or a blood pressure med held because of a fever). Information like this is typically not recorded on a MAR.

It is recognized that time may not allow an external transfer medication list to be completed, for example, when a patient is rapidly decompensating. Under these circumstances, the patient is usually transferred from a lower level of acute care to a higher level of acute care. The minimum requirements for documentation sent with the patient are the previous 24 hours of:
  I.   the MAR,
  II. the most recent physician orders, and

III.   the BPMH* (i.e., completed Preadmission Medication List / Prescriber Order Form, also known as the PIP).

*Only one BPMH / Preadmission Medication List / Prescriber Order Form / PIP is collected during an acute inpatient episode and it is usually collected by the first acute facility. This BPMH is used for MedRec at all transfers between acute facilities during the episode (regardless of number) and at the final discharge to home, long-term care (LTC) or supportive care.

Note that receiving sites with electronic capability may decide to reprint the PIP due to site-specific policies even though a PIP might have accompanied the patient from the sending facility.

5. What are the steps to completing the DTMR Form and signing it off?

The discharge/transfer MedRec process may involve four steps, all performed by a single person or each step carried out by a different person.

Step 1: List the active inpatient meds in section 1 and the stopped/held meds from pre-admission in section 2. *For sites that have implemented the pharmacy software (BDM), the list of active meds in section 1 is prepopulated. The pre-admission meds in section 2 may be pre-populated or require manual completion depending on local hospital pharmacy procedures.*

Step 2: (a) Compare the list of active meds in section 1 to the Best Possible Medication History (Preadmission Medication List / Prescriber Order Form). Ensure all home medications continued in hospital are captured in section 1. Check each medication as "Same as prior to admission", "Adjusted in hospital" or "New in hospital" and document relevant rationale/indication. The MAR and physician/prescriber order sheets for the last 72 hours need to be compared with section 1 as well.

(b) Compare the list of stopped/held meds at admission in section 2 to the Best Possible Medication History (Preadmission Medication List / Prescriber Order Form) for completeness and document relevant rationale, comments and discrepancies found in either section. **"Completed by" is signed by the person completing steps 1 and 2.**

Step 3: Prescriber reviews all sections, resolves discrepancies, and orders medications with quantity and refills specified in all sections, including ordering new meds to start after discharge.

Step 4: Confirm that the form is complete and identify discrepancies to be reconciled. Sign the "Reviewed by" line as a 'countersignature' to verify that the form is complete (Signing does not imply that the second person completed the form in its entirety; SRNA Documentation: Guidelines for Registered Nurses, Section 2.3). A signature in the authorized prescriber box and a blank "Reviewed by" line indicates the prescriber has reconciled the medications**. "Reviewed by" is signed by the person completing step 4.**

Note:
There may be variation across the province about who carries out the different steps. A prescriber can complete all the steps - but an authorized prescriber <u>must always</u> perform step 3.

Someone performing more than one step need only sign once on each page using a curly or angle bracket to indicate steps performed. See illustration below:

6. How is the allergy box completed?

The allergies will auto-populate in the allergy box at the top of the computer generated forms from the information received on the PIP/BPMH or the regional allergy/intolerance document. On paper-based forms, the allergy information is transcribed from the PIP/BPMH or the region-specific allergy/intolerance document. A copy of the regional allergy/intolerance document may be attached to the completed Form with a note in the allergy box to refer to the attached Allergy/Intolerance form.

7. Which healthcare providers can initiate the DTMR Form?

Nurses, including RNs, RPNs and LPNs, physicians, nurse practitioners, pharmacists, and midwives may initiate the Form. In some areas, pharmacy technicians may also be able to initiate the Form.

8. Which healthcare providers can finish the DTMR Form?

If a patient is being discharged to home or LTC, only an authorized prescriber can finish the Form by resolving discrepancies and authorizing its use as a prescription (see Q9).

If a patient is being transferred to another acute inpatient facility, time may not allow for an authorized prescriber to resolve discrepancies. In these situations, nurses, including RNs, RPNs and LPNs, nurse practitioners, and pharmacists may finish the DTMR Form but must clearly document that any identified discrepancies were not resolved prior to transfer. The BPMH / Preadmission Medication List / Prescriber Order Form, the most recent 72-hours of the MAR and prescriber orders sheet must accompany the DTMR Form.

9. Who are authorized prescribers?

Authorized prescribers may include physicians, nurse practitioners, pharmacists, midwives, and oral dental surgeons, as per area procedure and the respective scope of practice.

10. Can nurses take verbal or phone orders from the prescriber for the DTMR Form? Can hospital pharmacists?

Nurses <u>cannot</u> take verbal or phone orders from an authorized prescriber as a discharge prescription for the DTMR Form. The prescriber orders must be completed by the most responsible provider specifying quantity and, if appropriate, refills. A verbal prescription must be communicated directly between a physician and the community pharmacist or pharmacy technician in the pharmacy where it will be filled. Refer to the Regulatory Bylaws of the College of Physicians and Surgeons (Section 17.1) which states: "All verbal prescriptions must be communicated directly between a physician and a pharmacist/pharmacy technician as opposed to agents for either licensed professional."

Note that for internal/external transfers, nurses <u>can</u> take phone orders from an authorized prescriber for inpatients, using the DTMR form (according to SHA medication policies).

For a prescription to be complete, the '1/12' checkbox needs to be ticked <u>or</u> a quantity/duration of treatment is written in the 'Quantity' column and an authorized prescriber's signature is printed at the bottom of the DTMR Form.

11. What if there are more meds than rows for orders?

The computer-generated form auto-populates for sections 1 and 2 (area specific). If more rows are needed for section 3, print another page for section 3 and number pages accordingly.

The paper-based DTMR Form contains three pages: the first page includes section 1; the second page includes sections 2 and 3; the last page includes section 3 and the comment box.

If more rows are needed for section 1, use another front page and continue listing active meds; this becomes page 2. If more rows are needed for section 2 or 3, then use another page and continue listing meds as needed. Number pages accordingly.

12. Do all home meds (i.e., preadmission meds) and PRNs need to be reconciled, including the Pre Printed Order sets (previously known as standing ward orders)? How far back do you have to check the MAR for PRNs?

All home medications and PRNs must be reconciled. Review <u>at least</u> the previous 72 hours of PRN use to determine the patient's symptom relief requirements. Use clinical judgement when deciding if the medication may be continued at discharge or transfer and include these in section 1 of the DTMR Form after listing the scheduled active medications if using the paper-based DTMR form.

The computer generated DTMR form auto-populates the active meds in section 1. The pre-admission meds in section 2 may be pre-populated (area-specific) or require manual completion, dependent on local pharmacy procedures.

If the patient has not used a PRN medication in the preceding 72 hours, and it was not used by the patient prior to admission, and it is not required for chronic disease management (e.g., inhalers and nebules for asthma or COPD), it may be left off the DTMR Form.

It is expected that transferred patients are assessed by the receiving care team for symptom relief needs, including bowel care, sedation and pain management, as per best practice.

When prescribers are reviewing Pre Printed Order Sets (PPOs), please consider the following:

- If the patient has demonstrated a regular pattern needing a PRN agent, consider scheduling that agent.
- If the patient is being discharged home or to a LTC facility and will need to continue treatment, clearly write as an outpatient prescription by checking the "Continue" box and writing a quantity and refill (optional).

13. How do I access or receive the DTMR Form when it is not in the patient chart at the time of discharge or transfer?

The distribution of the DTMR Form at a particular site is dependent on area procedure or practice. Contact your pharmacy department, manager or MedRec lead for more information on your area processes.

Blank MedRec discharge/transfer forms, whether paper-based forms or the computer-generated BDM form, need to be available on site for use under the following circumstances:
- When the patient has been admitted, discharged/transferred, and the prescriber orders have not been processed/entered by pharmacy into the BDM system to produce an auto-populated form.
- In rural acute care sites with limited remote pharmacy services on weekends and statutory holidays, and the auto-populated form generated in the patient's chart needs to be updated thereby requiring more space.
- If a patient is discharged or transferred when pharmacy services are unavailable and the auto-populated form cannot be generated.
- Extra blank pages are needed to complete a lengthy external transfer medication list or discharge prescription in one or any of the sections of the Form.
- To cover contingency plans for system/fax/printer failures.

Community Pharmacy

14. Can a community pharmacy use prescriptive authority to fill in missing information on an incomplete DTMR Form?

An improperly completed DTMR Form is not a legal prescription and the pharmacist will follow up with the prescriber. Like any prescription, the community pharmacist may need to phone for clarification on the prescriber's intent if they are unable to determine it from the DTMR Form. Depending on the degree of completeness, the pharmacist may be able to use prescriptive authority to 'fill in the blanks'.

15. How are meds not dispensed by community pharmacy (e.g., tuberculosis treatment, cancer treatment) addressed?

In the comments column, write "followed by TB program" or "followed by cancer clinic" as appropriate.

16. What does the 'No Rx Needed' column mean?

An authorized prescriber may check off the 'No Rx Needed' tick box under the following situations:

If the patient reports having adequate supply of the medication at home already, a prescriber checks this column when the decision is made to:
- Continue a prescription the patient was on prior to admission to hospital (section 1).
- Restart a pre-admission medication not ordered/stopped in hospital (section 2).

Detailed explanation:
- When the attending physician is not the physician that prescribed the patient's home medications, the 'No Rx Needed' box may be checked. If the medications do not have any contraindications with the new medications prescribed, physicians may decide to leave the current prescription in place, thereby checking the 'No Rx Needed' column with instructions to follow up with their regular physician as required.

  Note that 'No Rx Needed' is checked off only when the medication, dose, route, frequency remains the same. If there is a change in any of the above mentioned, then it becomes a new medication. This is hand written into the 'New Medications to START after discharge' section (section 3).

- The 'No Rx Needed' tick box may be checked for OTC medications previously taken at home and prescriber has no intent of ordering them as a prescription but indicates patient should continue to take them at home. The 'No Rx Needed' tick box is also checked when preadmission medications are continued and all medications are checked off as "same as prior to admission", then the physician would use the "No Rx Needed" column to complete the DTMR.

- When a patient has a prescription for OTC medications, and the patient needs refills or the prescription has expired, the expectation is that the patient returns to the most responsible physician for refills or a new prescription. The 'No Rx Needed' tick box may be checked in these situations. In some cases, the pharmacist may have prescriptive authority for these medications.

17. What must be present for prescriptions to be filled by pharmacy?
- Either the 'Prescription – Discharge to Home' or 'Prescription – Discharge to LTC' check box is ticked.
- In section 1, Active Inpatient Medications, under Prescriber Orders, the 'Continue' column is checked off and the '1/12' checkbox is either ticked or a quantity/duration of treatment is written in the 'Quantity' column.
- In section 2, Pre-admission Medications as listed on BPMH, medications where the 'Restart' column is checked and 'Quantity' specified.
- In section 3, New Medications to Start after discharge, medications are handwritten in with 'Quantity' specified

18. How are decisions on 'held' meds during hospital stay recorded on the DTMR form?

Write in "Restart" or "Stop med" in the 'Comments/Rationale/Indication' column of the DTMR form so the prescriber can circle the option that is wanted or cross off the option that is not

wanted. Do not transcribe the 'Hold' meds into section 2. Section 2 remains for medications stopped on admission (appeared on the BPMH, but not part of the active meds on the DTMR). This serves as a double check that the intention of the prescriber checking off the "Continue" or "Stop" columns is clear. Refer to example below:

Prescription Elements – Quantity, Refills, Etc.

19. How long is the DTMR Form valid as a Rx?

The Form as a prescription is valid for one year, provided the prescriber is attending the patient (*Standards of Practice for Saskatchewan Pharmacists*, Saskatchewan College of Pharmacy Professionals; page 4). This applies to prescription drugs, narcotics, controlled drugs and targeted substances.

A prescription becomes invalid when it exceeds 12 months of age or when the prescriber ceases to attend the patient for reasons such as, but not limited to, death or retirement.

20. If there are narcotics and/controlled substances on the DTMR Form, can it be used as the prescription or does a separate prescription using a prescription pad need to be used for them?

The DTMR Form may be used to prescribe narcotics and controlled substances. However, the prescriber must include the quantity in both numeric and written format [e.g., 30 (thirty)] for the prescription to be legal. The tick box should not be used.

21. Where do I write the quantity in written form for Prescription Review Program agents (narcotics, controlled substances and gabapentin)?

The written form of quantity [e.g., 30 (thirty)] may be written in the space provided under the 'tick box' in the "Quantity" column in the "Prescriber Orders" section, or in the "Comments/Rationale/Indication" column. Note that the tick box should not be used.

For lengthier instructions such as part-fill directions, more than one row can also be used to write the order. Illustrations are provided below.

Example 1:

Example 2:

22. What if the prescriber doesn't complete the quantity and/or refills for each medication?

Quantity or duration of treatment is a required element of a legal prescription. Authorization of refills is optional.

When the quantity is not completed, a community pharmacist may insert the missing quantity if the pharmacist is satisfied that the prescriber's intent is clear, and that the necessary information was unintentionally omitted. The pharmacist who inserts the missing information must notify the prescriber of the information inserted and the drug that was dispensed. In either case, omission of this information leads to follow-up by the community pharmacist.

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The intent of MedRec at discharge is for clear communication to the patient and the community pharmacist about the patient's medications following discharge. If the community pharmacist has to call the prescriber for either clarification of quantity to dispense, or notification about what was done, then communication was not clear.

23. If prescriber does not complete quantity, how much can the community pharmacist dispense?

Quantity or duration of treatment is a required element of a legal prescription. For narcotic and controlled substances, the prescriber must specify the quantity to be dispensed (refer to the *Controlled Drugs and Substances Act, Narcotic Control Regulations and the Prescription Review Program*).

For all other medications, under prescriptive authority (except for narcotics, controlled substances, benzodiazepines and gabapentin), the pharmacist may be able to insert the missing information if the prescriber's intent is clear; this is followed by notifying the prescriber of the action taken. If the intent is unclear and they are unable to determine quantity from the prescription, the pharmacist must clarify it with the prescriber. In either case, the community pharmacist is required to follow up with the prescriber.

24. Do prescribers complete the refills section if they know the patient has refills ordered previously?

No. New prescriptions cancel out existing refills for medications, and previously ordered refills are irrelevant because of this. However, if the prescriber is certain the patient has refills remaining AND there have been no changes to the medication while admitted to hospital, the prescriber should indicate "Continue" and check "No Rx Needed" if the prescriber does not wish to reissue a prescription for the medication. This will inform the patient's community pharmacy that the patient is to continue the medication, and that the existing prescription may be used to enable this.

Faxing a Prescription

25. Can the DTMR Form be faxed to the prescriber to complete, and faxed back to the discharging facility for the discharging facility to fax to the community pharmacy (e.g., a patient cannot be discharged until their lab results report a certain value, and in the meantime the prescriber has left the facility)?

No (see Online Reference Manual of the Saskatchewan College of Pharmacy Professionals: *Electronic Transmission of Prescriptions – Supplementary Guidelines 4.1*).

The prescription must be faxed directly to the community pharmacy of the patient's choice, and must be sent directly from the prescriber's office OR directly from a healthcare institution for a patient of that institution.

- Physician office to community pharmacy √
- Hospital original with signature to community pharmacy √
- Hospital original to physician office with signature to community pharmacy √

- Physician office to hospital to community pharmacy X

26. If the patient is being discharged home and the DTMR Form is being faxed to the community pharmacy, is a copy of the DTMR Form given to the patient?

Yes. The DTMR Form is photocopied, marked as a copy, then given to the patient along with the discharge care plan. It is a communication piece and complements the discharge care plan. Check off 'Copy to patient' and write in date in the "Copied/Faxed to" section at the end of the DTMR Form. Original must be filed in patient chart.

27. If the DTMR Form is faxed to a community pharmacy of the patient's choice on discharge, and the patient chooses to switch pharmacies AFTER the Form is faxed, can the DTMR Form (i.e., prescription) be transferred to another community pharmacy?

Yes, as long as the original community pharmacy is open. At the request of the patient, the community pharmacy that received the faxed Form can transfer it to another community pharmacy with the following exceptions:
- Prescriptions for narcotics and controlled substances cannot be transferred, and
- Prescriptions for targeted substances may be transferred only once

(see the *Saskatchewan College of Pharmacy Professionals Reference Manual*, Prescription Regulations Summary Chart).

If the original prescription was faxed to the wrong pharmacy ("pharmacy A"), it is best that the hospital fax the prescription to the correct pharmacy and notify pharmacy A so the first prescription can be shredded.

28. Do all the pages need to be faxed, even ones with no medications?

All pages must be faxed. If an auto-populated DTMR Form is being used, all pages must be faxed regardless of how the blank pages are documented because the page numbering is also auto-populated and all numbered pages must be included in the fax.

Prescriber Signatures

29. Do prescribers have to sign a blank page if there are no medication orders?

No. A blank page should not be signed by a prescriber. This would be like signing a blank cheque or a blank prescription pad.

If the prescriber chooses to sign a blank page, the fill sections, blank or empty rows must be crossed out. Conversely, if a page is crossed out, it must be signed. This indicates that the page had been reviewed and prevents medications being added after the prescriber has signed the page.

30. Can a prescriber complete the DTMR Form for another prescriber while caring for that prescriber's patients?

Yes. Best practice would be to have the most responsible prescriber complete the Form, but if that prescriber is unavailable, another prescriber could complete the Form as long as all the

steps are still followed. A note should be made to have the patient follow up with their usual prescriber.

31. Can a second prescriber change medication orders on the DTMR Form, once completed, signed and dated by the first prescriber?

No. This form is considered a prescription and therefore only one prescriber can complete it. If there is more than one prescriber involved in the patient's care, there should be one prescriber who is most responsible and completes the form with input from others if needed.

32. Can prescribers co-sign the Form if they both want to order medications (e.g., GP & psychiatrist)?

No, the two prescribers must consult. One then assumes responsibility on behalf of both, and signs the DTMR as the Most Responsible Physician. A note should be made to have the patient follow up with the other prescribers involved in their care, as required.

33. Do prescribers have to sign the DTMR Form if the patient is being transferred to another acute care facility?

No, with the following exception.

Exception: If the patient is being transferred to an acute facility within the same area, and the area procedure is such that the orders written by the sending prescriber will be accepted as admission orders by the receiving facility, then yes, the prescriber must sign the DTMR Form (see Q3).

34. Do prescribers have to sign the Form if only PRNs are ordered?

Yes. All prescription and over-the-counter drugs, whether PRN or regularly scheduled, need to be reviewed and reconciled, and require a prescriber's signature at discharge.

Prescriber Privileges

35. When a patient is being discharged to a LTC facility's home care or transition units, can the admitting orders be accepted by the LTC facility if the prescriber does not have privileges in the receiving LTC facility?

This is dependent on area procedures.

There are areas whose physicians have admitting privileges in all LTC facilities. In these areas, MedRec discharge orders are their admitting medication orders, which allow patients to receive the meds they need when they need them (see Q2). The physician taking over the care of the resident can review the admitting orders and has the ability to make any changes as appropriate at any point. Otherwise, the admitting physician in the LTC facility home care or transition unit has to complete admitting orders/MedRec at Admission.

Automatic Substitutions

36. How are automatic therapeutic substitutions documented and reconciled at discharge?

This varies according to area pharmacy procedures.

Typically, the therapeutic substitution is listed in section 1 as the active med and the substituted med is listed in section 2 as held at admission. The person reconciling the DTMR Form uses the "Comments/Rationale/Indication" column to flag this for the prescriber. The prescriber decides whether to continue with the substitution or to stop the substitution and restart the pre-admission med.

37. How do we document automatic substitution of fixed-dose combination products with single ingredient products (e.g., patient uses Hyzaar® at home, and the hospital pharmacy substitutes with losartan and hydrochlorothiazide while the patient is in hospital)?

This varies according to area pharmacy procedures.

Typically, the two single ingredient products are listed in section 1 as active meds, and the fixed-dose combination product is listed in section 2 as held at admission. The person reconciling the DTMR Form uses the "Comments/Rationale/Indication" column to flag this for the prescriber. The prescriber decides what the patient is to use upon discharge.

No Prescription Medications

38. Does the patient need the DTMR Form on discharge when prescription meds are not ordered? Does the discharging facility fax the DTMR Form to the community pharmacy?

The DTMR Form **is faxed** by the discharging facility to the community pharmacy:

- If the patient was admitted to hospital with active medications, but is discharged with none (i.e., everything is discontinued) then the Form becomes a communication tool for the community pharmacist (i.e., previously prescribed medications discontinued and why).
- If the patient is to receive only over-the-counter (OTC) medications and is being discharged to a LTC facility, the Form should be faxed to the appropriate community pharmacy.
- If the patient is receiving only OTC medications and is being discharged home, explain to the patient that the prescriber has ordered OTC meds only, and have it faxed to the community pharmacy of the patient's choice. Patients can request a copy of the DTMR form so they know how to take their medications if they decide to purchase the OTC drugs elsewhere or not fill it at all due to having a steady supply at home. Orders should be written as if it is being written for a prescription drug.
- If a patient's home medications **are continued on admission**, and there are no medication changes at all while in hospital, and no new medications were prescribed on discharge, then in the Active Inpatient Medications section, section 1, the 'Same as prior to admission' and the 'No Rx Needed' column (checked off by the prescriber) is checked off for all medications. The Form is completed by drawing a line through the empty rows in section 2 and 3. *Faxing of this form to community pharmacy in this situation would be for information purposes only.*

- Other reasons for faxing OTC-only prescriptions to the community pharmacy include:
  - Clear communication to the community pharmacist about what the patient should be taking on discharge (e.g., naproxen to be taken short-term only for an acute condition; low-dose ASA for a cardiac condition);
  - Third party coverage, should the patient have it (e.g., First Nations, employer-sponsored plans like Blue Cross);
  - More medications are moving from prescription to OTC status.

The DTMR Form is not faxed to the community pharmacy:

- If the patient was admitted to hospital with **no medications** and is discharged with no medications, then the DTMR Form is not taken by the patient, nor faxed by the discharging facility to the community pharmacy. Under these circumstances, complete the DTMR Form by drawing a line through the empty rows or sections to indicate that the medication review and reconciliation process occurred and was not missed (see also Q39 &43). This will also prevent the addition of medications to the Form after the patient has been discharged.

Discharge Care Plan and MedRec

39. On discharge, when a patient is handed his/her DTMR Form (when a pharmacy is not identified), do their medications also need to be documented on their discharge care plan?

No, but the completed DTMR Form should be referenced on the discharge care plan, unless area procedure dictates otherwise.

Late Discovery of Discrepancies

40. What is the appropriate process should a discrepancy be discovered after the prescriber has signed the Form and has the left facility (e.g., diabetic med stopped and no new diabetic med ordered for a known diabetic patient)?

Notify the prescriber immediately.

On the DTMR Form, flag the discrepancy that was not resolved prior to discharge.   Document on the DTMR Form the discrepancy and the follow-up action with the prescriber in the "Other Medication Instructions/Comments" box on the last page, and note that the discrepancy was identified after the prescriber signed the Form and left the unit/facility. The prescriber can:

- Return to the unit/facility to correct the discrepancy directly onto the form prior to sending it to the Community Pharmacy. If section 3 of the Form is blank, the prescriber may add the new order and sign and date the last page. If section 3 has been crossed out, a clean page will need to be printed for the prescriber to add the new order, sign, and date. The new page should be attached and numbered accordingly.
- Write a prescription for the new medication. Note that if the DTMR has already been faxed to the Community Pharmacy, the prescriber will need to contact the Community Pharmacy directly to clarify the discrepancy (see Q10).

41. What is the appropriate process should a discrepancy be discovered after the signed DTMR Form has been faxed to the community pharmacy?

Notify the community pharmacy and the prescriber immediately, and document follow-up on the Form being sure to note that this happened after the DTMR Form had been faxed. The responsibility for obtaining an order for the new med is now that of the community pharmacy and prescriber (see Q39).

Newborns and mothers

42. Does a DTMR Form need to be completed for a newborn, or for the mother only?

Normal healthy newborns (i.e., admitted to normal nursery or mother's bedside) do not require medication reconciliation at any transition point.

Newborns with mothers who are chemically dependent, HIV positive, or on antiretroviral (ARV) medications require referral to pharmacy, and medication reconciliation is required at all transition points.

Other newborns admitted or transferred to NICU require MedRec at transfer back to normal nursery or discharge home.

Yes, the DTMR Form needs to be completed for the mother.

Incomplete Medication Transfer Documentation

43. How do I thoroughly complete the DTMR Form on discharge to home for patients who had been transferred from another facility that has not implemented MedRec on discharge/transfer, and copies of the completed Preadmission Medication List / Prescriber Order Form (i.e., BPMH) and MAR were not sent with the patient?

Contact the sending facility as soon as possible and request a copy of the completed Preadmission Medication List / Prescriber Order Form done at admission in the sending facility, the most recent 24-72 hours of MARs and last 72-hours of medication orders. This should be done as soon as possible to avoid the receiving facility having to chase down the chart.

44. If there are no pre-admission medications, how is this documented on the DTMR Form?

A line is drawn through the empty section or rows.

Miscellaneous

45. How are discontinued or stopped medications appropriately documented on a MAR / DTMR Form that is to be copied or faxed?

Legibly write "Discontinued" with the date beside the medication and/or cross it out with ink. It may also be highlighted in yellow but not without written documentation. Yellow highlighting does not fax and therefore should never be used as the sole method of documentation.

46. How are meds that can be prescribed only by certain prescribers (e.g., methadone for opioid agonist therapy (OAT), cancer agents, TB meds, etc.) handled?

If the patient was managed by a methadone prescriber (OAT) prior to admission, the most responsible physician (Hospital Based Temporary Prescriber) has the ability to order a maintenance dose (dose and frequency to remain the same from admission) using the DTMR accordingly for a maximum of 72 hours after discharge from a facility on a weekend until the patient can schedule a follow up appointment with the methadone prescriber. Note that the numerical and written quantities are required. The community methadone prescriber must be notified at discharge that methadone (OAT) was prescribed to avoid double dosing (*refer to Opioid Agonist Therapy Program. STANDARDS AND GUIDELINES for the Treatment of Opioid Use Disorder (p. 22) Sask. College of Physicians and Surgeons*).

In the "Comments/Rationale/Indication" column, write "Follow up with an authorized methadone prescriber" or as appropriate for other specialized medications such as cancer agents, TB medications. Etc.

47. How are meds requiring an infectious disease consult in order to be covered by the Drug Plan under the Exception Drug Status (EDS) program (e.g., treatment of HIV/AIDS) handled?

EDS criteria for HIV/AIDS drugs require a consult with an infectious disease (ID) specialist.

If the patient is newly diagnosed during the hospital stay, the consult with an ID specialist will have occurred. The prescriber should write in the "Comments/Rationale/Indication" column that the ID consult has occurred. If the family physician writes the initial prescription for HIV/AIDS drugs on discharge, the family physician must call in for EDS if not already done by the ID specialist.

If the patient is chronic and being managed by a family physician, it is likely all the criteria have been met and the approvals in place. No extra documentation is required.

48. What happens if the DTMR Form is completed but the patient's discharge is cancelled or there is a change in orders?

This may vary by area procedures.

If there are medication changes, the signed DTMR Form should be voided with an explanation of the circumstances, and the process starts over.

If there are no changes to medication orders between the time that the discharge was cancelled and when the patient does leave, the previously completed and reconciled form is valid. A review of the form should occur; a signature and date indicating this review was completed must be written on the form.

49. What is the process for completing the DTMR Form if the patient doesn't return from a 'pass' or leaves against medical advice, or by police custody?

Document on the Form that the "patient did not return from pass", "patient left against medical advice" or "patient left by police custody" respectively, or according to your area procedure. Notify the attending prescriber as appropriate.

50. Do 'non-admitted' ER patients that meet the criteria to have a BPMH completed on the Preadmission List / Prescriber Order Form need the DTMR Form completed when leaving the ER?

No. These patients are **not admitted**, and therefore, do not have their medications entered into the BDM computer system. As such, a DTMR Form cannot be generated, nor do they require a blank / paper-based DTMR Form to be completed. Any medications that need to be prescribed for these patients need to be written on a prescription pad like all other patients leaving the ER. If it is deemed that these 'non-admitted' patients are to be admitted due to special circumstances, refer to area procedure for the admission process.

Appendices:

A. Example of completed (electronic generated DTMR Form used as a discharge prescription.

SK Discharge/Transfer Medication Reconciliation Form
Saskatchewan Health Authority

Location: SHA WEG 3E E304 3

Dog, Pug		
Age: 57 yrs	HSN:	103425756
DOB: 09/09/1960	MRN#:	58299
Gender: M	Admitted: Jun 12, 2018	

Allergies: Penicillins [Rash]

Patient Address: 222 Albert Street
Regina, SK S4S6X6

Prescription - Discharge to Home ☐   Prescription - Discharge to LTC ☒   Transfer Medication List - External ☐
Transfer Orders - Internal ☐

Community Pharmacists: For refills beyond what is listed below, please contact family physician/nurse practitioner.

1. Active Inpatient Medications
Review MAR and prescriber order sheets for last 72hrs

Scheduled medications, followed by PRN active prior to discharge

Medication	Dose / Route / Frequency	Same as prior to admission	Adjusted in hospital	New in hospital	Comments / Rationale / Indication	Continue	Quantity Discharge Only	Refills Discharge Only	No Rx Needed	STOP
Scheduled Medications:										
ENOXAPARIN PDS INJ 40 mg/0.4 mL (LOVENOX	40 MG SUBCUT ONCE DAILY AT SUPPER (Lovenox) Sched: 17:00		✓				☐½ Or			✓
ACETYLSALICYLIC ACID EC TAB 81 mg	81 MG (1 TAB) PO DAILY (Aspirin) Sched: 09:00	✓				✓	☐½ Or		✓	
HYDROmorphone Slow Rel 3 mg	3 MG (1 CAP) PO Q12H (HYDROmorph CONTIN, HYDROmorphone) Sched: 09:00, 21:00	✓			dispense: 68 (sixty eight)	✓	☐½ Or			
PANTOPRAZOLE SODIUM EC TAB 40 mg	40 MG (1 TAB) PO ONCE DAILY (PPI) (Pantoloc) Sched: 07:30		✓		decreased from bid	✓	☑½ Or			
LEVOTHYROXINE tab 75 mcg (SYNTHROID)	75 MCG (1 TAB) PO ONCE DAILY 30 MIN BEFORE BREAKFAST (Synthroid/Eltroxin) Sched: 08:00	✓				✓	☑½ Or			
PRN Medications:										
SALBUTAMOL NEB 2.5 mg/2.5mL	2.5 MG (2.5 ML) VIA NEB Q6H PRN (Ventolin)		✓				☐½ Or			✓
HYDROmorphone Immed Rel 1 mg	1 MG (1 TAB) PO Q6H PRN (Dilaudid)	✓			dispense: 100 tabs (one hundred)	✓	☐½ Or			
ACETAMINOPHEN tab 325 mg	325 TO 650 MG (1-2 TABS) PO Q4H PRN		✓				☐½ Or			✓

Completed by: _Nurse White_ RN
Date: 19 June 2018 Time: 09:00

Reviewed by: _Nurse Betty_ RN
Date: 19 June 2018 Time: 11:00

Authorized Prescriber:	#: 1234
Dr. Doctor	
(sign)	(print)
Phone #: 123-4567	(sign)
Date: 18 June 2018	
123 Hospital Street, Anywhere, SK	

CONFIDENTIALITY NOTICE: The content of the communication is confidential and contains personal health information. It is intended solely for the use of the patient's health care providers. If you have received this communication in error, immediately notify the sender by return fax and destroy all originals and copies of the misdirected communication.

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SK Discharge/Transfer Medication Reconciliation Form

Saskatchewan Health Authority

Location: SHA WEG 3E E304 3

Dog, Pug

Age:	57 yrs	HSN:	103425756
DOB:	09/09/1960	MRN#:	58299
Gender: M		Admitted:	Jun 12, 2018

1. Active Inpatient Medications (continued)
Review MAR and prescriber order sheets for last 72hrs

Scheduled medications, followed by PRN active prior to discharge

Medication	Dose / Route / Frequency	Same as prior to admission	Adjusted in hospital	New in hospital	Comments / Rationale / Indication	Continue	Quantity Discharge Only	Refills Discharge Only	No Rx Needed	STOP
dimenhyDRINATE tab 50 mg	25 MG (0.5 TAB) PO Q6H PRN (Gravol)			✓			☐ ½₁₂ Or			✓

Medications Ordered After Time of Printing:

							☐ ½₁₂ Or			
							☐ ½₁₂ Or			
							☐ ½₁₂ Or			
							☐ ½₁₂ Or			
							☐ ½₁₂ Or			

2. Pre-admission medications as listed on Best Possible Medication History

RESTART pre-admission medications not ordered or stopped in hospital
STOP pre-admission medications no longer required

Medication	Dose / Route / Frequency	Comments / Rationale / Indication	Restart	Quantity Discharge Only	Refills Discharge Only	No Rx Needed	STOP
AMITRIPTYLLINE 10MG TABLET	TAKE 1 TABLET DAILY HELD ON ADMISSION	Stopped on admission Sleeping well without		☐ ½₁₂ Or			✓
AMLODIPINE 5MG TAB (NORVASC)	TAKE 1 TABLET DAILY STOPPED	held on admission due to low BP please resume	✓	☑ ½₁₂ Or			
				☐ ½₁₂ Or			
				☐ ½₁₂ Or			
				☐ ½₁₂ Or			
				☐ ½₁₂ Or			

Completed by: _Nurse White_ RN

Date: _19 June 2018_ Time: _09:00_

Reviewed by: _Nurse Betty_ RN

Date: _19 June 2019_ Time: _11:00_

Authorized Prescriber: #: _1234_

Dr. Doctr

_(M)_   (print)

Phone #: _123-4567_   (sign)

Date: _19 June 2019_

Version: BDM.2.11.

Printed on: 2018-Jun-19 at 14:12:23 with job id#:38285127

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SK Discharge/Transfer Medication Reconciliation Form

Saskatchewan Health Authority

Location: SHA WEG 3E E304 3

Dog, Pug

Age:	57 yrs	HSN:	103425756
DOB:	09/09/1960	MRN#:	58299
Gender: M		Admitted:	Jun 12, 2018

2. Pre-admission medications as listed on Best Possible Medication History

RESTART pre-admission medications not ordered or stopped in hospital
STOP pre-admission medications no longer required

Medication	Dose / Route / Frequency	Comments / Rationale / Indication	Restart	Quantity Discharge Only	Refills Discharge Only	No Rx Needed	STOP
				☐ ½₂ Or			
				☐ ½₂ Or			
				☐ ½₂ Or			
				☐ ½₂ Or			

Prescriber Orders — Also add written quantity for narcotics, controlled substances, benzodiazepines, and gabapentin

3. NEW medications to START after discharge

Medication	Dose / Route / Frequency	Comments / Rationale / Indication	Quantity Discharge Only	Refills Discharge Only
Keflex 500	qid × 7 days		☐ ½₂ Or	
			☐ ½₂ Or	
			☐ ½₂ Or	
			☐ ½₂ Or	
			☐ ½₂ Or	
			☐ ½₂ Or	
			☐ ½₂ Or	

Prescriber Orders — Also add written quantity for narcotics, controlled substances, benzodiazepines and gabapentin

Completed by: Nurse White RN
Date: 19 Jne 2018 Time: 0900

Reviewed by: Nurse Betty RN
Date: 19 Jne 2018 Time: 11:00

Authorized Prescriber: #: 1234
Dr. Doctr
(print)
Phone #: 123-4567 (sign)
Date: 19 June 2018

Version: BDM 2.11.

Printed on: 2018-Jun-19 at 14:12:23 with job id#:38285127

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SK Discharge/Transfer Medication Reconciliation Form
Saskatchewan Health Authority

Location: SHA WEG 3E E304 3

Dog, Pug			
Age:	57 yrs	HSN:	103425756
DOB:	09/09/1960	MRN#:	58299
Gender: M		Admitted: Jun 12, 2018	

Other Medication Instructions/Comments:

Copied/Faxed to:	Name of Recipient / Fax #	Date	Copied/Faxed to:	Name of Recipient / Fax #	Date
☑ Community Pharmacy	Coop Pharmacy 123-7890	19 June 2018	☐ Receiving Facility		
☑ Long Term Care	Seniors Haven 321-0000	19 June 2018	☐ Family Physician/ Nurse Practitioner		
☐ Home Care			☐ Other ☐ Copy to patient		

Please note: If faxed to Community Pharmacy, stamp original FAXED and retain in chart.

Completed by: _Nurse White_ RN

Date: _19 Jun 2018_ Time: _0500_

Reviewed by: _Nurse Betty_ RN

Date: _19 Jun 2018_ Time: _0900_

Authorized Prescriber:	#: 1234
Dr. Dr	
	(print)
Phone #: 123-4567	(sign)
Date: 19 Jun 2018	

Printed on: 2018-Jun-19 at 14:12:23 with job id#:38285127

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B.   Example of completed DTMR Form used as a Transfer Medication List – Sending site.

SK Discharge/Transfer Medication Reconciliation Form
Saskatchewan Health Authority

Example "Sending Site"

Location: SHA YRH ICUS

TEST PATIENT			
Age:	76 yrs	HSN:	888888888
DOB:	20/06/1942	MRN#:	000123456
Gender: <None>		Admitted:	Nov 14, 2017

Allergies: No Known Drug Allergy

Patient Address:

Prescription - Discharge to Home ☐	Prescription - Discharge to LTC ☐	Transfer Medication List - External ☑
		Transfer Orders - Internal ☐

Community Pharmacists: For refills beyond what is listed below, please contact family physician/nurse practitioner.

1.   Active Inpatient Medications
Review MAR and prescriber order sheets for last 72hrs

		Medication Status				Prescriber Orders Also add written quantity for narcotics, controlled substances, benzodiazepines, and gabapentin				
Scheduled medications, followed by PRN active prior to discharge		Same as prior to admission	Adjusted in hospital	New in hospital	Comments / Rationale / Indication	Continue	Quantity *Discharge Only*	Refills *Discharge Only*	No Rx Needed	STOP
Medication	Dose / Route / Frequency									
Scheduled Medications:										
ENOXAPARIN PDS INJ 40 mg/0.4 mL (LOVENOX	40 mg SUBCUT HS DISCONTINUE VTE PROPHYLAXIS ON DISCHARGE, UNLESS ORTHOPEDIC PATIENT Sched: 21:00			✓			☐ ½₂ Or			
ACETYLSALICYLIC ACID EC TAB 81 mg	81 mg (1 TAB) PO DAILY Sched: 09:00	✓					☐ ½₂ Or			
HYDROmorphone Slow Rel 3 mg	3 mg (1 cap) PO BID (HYDROmorph CONTIN, HYDROmorphone) Sched: 09:00, 21:00	✓					☐ ½₂ Or			
PANTOPRAZOLE SODIUM EC TAB 40 mg	40 mg (1 TAB) PO DAILY (PANTOLOC) BEFORE MEALS Sched: 08:00		✓		↑ from 20mg daily		☐ ½₂ Or			
LEVOTHYROXINE tab 75 mcg (SYNTHROID)	75 mcg (1 TAB) PO DAILY Sched: 08:00	✓					☐ ½₂ Or			
PRN Medications:										
SALBUTAMOL NEB 2.5 mg/2.5mL	2.5 MG (2.5 ML) VIA NEB Q6H PRN		✓				☐ ½₂ Or			
NITROGLYCERIN SL SPRAY 0.4MG/SPR(75 DOSE	0.4 MG SUBLINGUAL EVERY 5 MINUTES FOR 3 DOSES PRN FOR CHEST PAIN		✓		PPO		☐ ½₂ Or			
HYDROmorphone Immed Rel 1 mg	1 MG (1 TAB) PO Q6H PRN	✓					☐ ½₂ Or			

Completed by: *Nurse A*   Title *RN*

    Date: *Nov 19/18* Time: *1400*

Reviewed by: _____ Signature ____ Title ____

    Date: _____ Time: _____

Authorized Prescriber:	#:_____
_____	(print)
_____	(sign)
Phone #: _____	
Date: _____	
Prescriber Address for orders for narcotics, controlled substances, benzodiazepines, and gabapentin	

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SK Discharge/Transfer Medication Reconciliation Form

Saskatchewan Health Authority

Location: SHA YRH ICUS

TEST PATIENT

Age:	76 yrs	HSN:	888888888
DOB:	20/06/1942	MRN#:	000123456
Gender: <None>		Admitted:	Nov 14, 2017

1. Active Inpatient Medications (continued)
Review MAR and prescriber order sheets for last 72hrs

Medication	Dose / Route / Frequency	Same as prior to admission	Adjusted in hospital	New in hospital	Comments / Rationale / Indication	Continue	Quantity Discharge Only	Refills Discharge Only	No Rx Needed	STOP
ACETAMINOPHEN tab 325 mg	650 MG (2 TAB) PO *OR NG/PR* Q4H PRN			✓	PPO		□ ½₁₂ Or			
METOCLOPRAMIDE tab 5 mg (METONIA)	10 MG (2 TAB) PO *OR NG/IV* Q6H PRN			✓	PPO		□ ½₁₂ Or			
ANTACID (MAGNESIUM/ALUMINUM) SUSP 350 mL	15 TO 30 ML PO PRN			✓	PPO		□ ½₁₂ Or			
dimenhyDRINATE TAB 50 MG	12.5 TO 50 MG PO Q4H PRN *OR NG/PR/IV* Q4H PRN (CONSIDER LOWER DOSE FOR FRAIL/ELDERLY)			✓	PPO		□ ½₁₂ Or			
ONDANSETRON TAB 4 MG	4 MG (1 TAB) PO *OR NG/IV* Q8H PRN (NON-SEDATING) **DISCONTINUE ON DISCHARGE**			✓	PPO		□ ½₁₂ Or			

Medications Ordered After Time of Printing:

Medication										
Zoplicone 5 mg po HS				✓			□ ½₁₂ Or			
							□ ½₁₂ Or			
							□ ½₁₂ Or			
							□ ½₁₂ Or			
							□ ½₁₂ Or			

Completed by: **Nurse A** Title **RN**

Date: **NOV 19/18** Time: **1400**

Reviewed by: _____ Signature _____ Title _____

Date: _____ Time: _____

Authorized Prescriber: #: _____

_____ (print)

_____ (sign)

Phone #: _____

Date: _____

Prescriber Address for orders for narcotics, controlled substances, benzodiazepines, and gabapentin

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SK Discharge/Transfer Medication Reconciliation Form

Saskatchewan Health Authority

Location: SHA YRH ICUS

TEST PATIENT

Age:	76 yrs	HSN:	888888888
DOB:	20/06/1942	MRN#:	000123456
Gender: <None>		Admitted: Nov 14, 2017

2. Pre-admission medications as listed on Best Possible Medication History

RESTART pre-admission medications not ordered or stopped in hospital
STOP pre-admission medications no longer required

Medication	Dose / Route / Frequency	Comments / Rationale / Indication	Restart	Quantity Discharge Only	Refills Discharge Only	No Rx Needed	STOP
Amitriptyline	10mg po daily	Stopped on admission		☐½₁₂ Or			
Amlodipine	5mg po daily	Stopped on admission		☐½₁₂ Or			
				☐½₁₂ Or			
				☐½₁₂ Or			
				☐½₁₂ Or			
				☐½₁₂ Or			
				☐½₁₂ Or			
				☐½₁₂ Or			

Prescriber Orders — Also add written quantity for narcotics, controlled substances, benzodiazepines, and gabapentin

Completed by: **Nurse A**   Title **RN**

Date: **NOV 19/18**   Time: **1400**

Reviewed by: _____ Signature _____ Title

Date: _____ Time: _____

Authorized Prescriber: _____ #: _____

_____ (print)

_____ (sign)

Phone #: _____

Date: _____

Prescriber Address for orders for narcotics, controlled substances, benzodiazepines, and gabapentin

SK Discharge/Transfer Medication Reconciliation Form

Saskatchewan Health Authority

Location: SHA YRH ICUS

TEST PATIENT			
Age:	76 yrs	HSN:	888888888
DOB:	20/06/1942	MRN#:	000123456
Gender: <None>		Admitted: Nov 14, 2017	

3. NEW medications to START after discharge

				Prescriber Orders	
Medication	Dose / Route / Frequency	Comments / Rationale / Indication		Quantity Discharge Only	Refills Discharge Only
				☐ ½₁₂ Or	
				☐ ½₁₂ Or	
				☐ ½₁₂ Or	
				☐ ½₁₂ Or	
				☐ ½₁₂ Or	
				☐ ½₁₂ Or	
				☐ ½₁₂ Or	

(Prescriber Orders note: Also add written quantity for narcotics, controlled substances, benzodiazepines, and gabapentin)

Other Medication Instructions/Comments:

Copied/Faxed to:	Name of Recipient / Fax #	Date	Copied/Faxed to:	Name of Recipient / Fax #	Date
☐ Community Pharmacy			☑ Receiving Facility	New Hospital 123-456-7890	Nov 19/18
☐ Long Term Care			☐ Family Physician/ Nurse Practitioner		
☐ Home Care			☐ Other ☐ Copy to patient		

Please note: If faxed to Community Pharmacy, stamp original FAXED and retain in chart.

Completed by: _Nurse A_ Title _RN_

Date: _Nov 19/18_ Time: _1400_

Reviewed by: _____ Signature _____ Title

Date: _____ Time: _____

Authorized Prescriber:	#: _____
	(print)
	(sign)
Phone #:	
Date:	
Prescriber Address for orders for narcotics, controlled substances, benzodiazepines, and gabapentin	

CONFIDENTIALITY NOTICE: The content of the communication is confidential and contains personal health information. It is intended solely for the use of the patient's health care providers. If you have received this communication in error, immediately notify the sender by return fax and destroy all originals and copies of the misdirected communication.

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C. Example of completed DTMR Form used as a Transfer Medication List – Receiving site.

SK Discharge/Transfer Medication Reconciliation Form
Saskatchewan Health Authority

Location: 3HA YRH ICU5

Example "Receiving site"
Admitting orders

TEST PATIENT			
Age:	76 yrs	HSN:	888888888
DOB:	20/06/1942	MRN#:	000123456
Gender: <None>		Admitted:	Nov 14, 2017

Allergies: No Known Drug Allergy

Patient Address:

Prescription - Discharge to Home ☐	Prescription - Discharge to LTC ☐	Transfer Medication List - External ☑ Transfer Orders - Internal ☐

Community Pharmacists: For refills beyond what is listed below, please contact family physician/nurse practitioner.

1. Active Inpatient Medications
Review MAR and prescriber order sheets for last 72hrs

Scheduled medications, followed by PRN active prior to discharge

Medication	Dose / Route / Frequency	Same as prior to admission	Adjusted in hospital	New in hospital	Comments / Rationale / Indication	Continue	Quantity Discharge Only	Refills Discharge Only	No Rx Needed	STOP
Scheduled Medications:										
ENOXAPARIN PDS INJ 40 mg/0.4 mL (LOVENOX	40 mg SUBCUT HS DISCONTINUE VTE PROPHYLAXIS ON DISCHARGE, UNLESS ORTHOPEDIC PATIENT Sched: 21:00			✓		✓	☐ ½₁₂ or			
ACETYLSALICYLIC ACID EC TAB 81 mg	81 mg (1 TAB) PO DAILY Sched: 09:00	✓				✓	☐ ½₁₂ or			
HYDROmorphone Slow Rel 3 mg	3 mg (1 cap) PO BID (HYDROmorph CONTIN, HYDROmorphone) Sched: 09:00, 21:00	✓				✓	☐ ½₁₂ or			
PANTOPRAZOLE SODIUM EC TAB 40 mg	40 mg (1 TAB) PO DAILY (PANTOLOC) BEFORE MEALS Sched: 08:00		✓		↑ from 20mg daily	✓	☐ ½₁₂ or			
LEVOTHYROXINE tab 75 mcg (SYNTHROID)	75 mcg (1 TAB) PO DAILY Sched: 08:00	✓				✓	☐ ½₁₂ or			
PRN Medications:										
SALBUTAMOL NEB 2.5 mg/2.5mL	2.5 MG (2.5 ML) VIA NEB Q6H PRN			✓		✓	☐ ½₁₂ or			
NITROGLYCERIN SL SPRAY 0.4MG/SPR(75 DOSE	0.4 MG SUBLINGUAL EVERY 5 MINUTES FOR 3 DOSES PRN FOR CHEST PAIN		✓		PPO		☐ ½₁₂ or			✓
HYDROmorphone Immed Rel 1 mg	1 MG (1 TAB) PO Q6H PRN	✓				✓	☐ ½₁₂ or			

Completed by: _Nurse A_ Title _RN_
Date: _Nov 19/18_ Time: _1400_

Reviewed by: _Nurse B_ Title _RN_
Date: _Nov 19/18_ Time: _1830_

Authorized Prescriber:	#: _____
Physician	
Physician	(print)
Physician	(sign)
Phone #: _xxx-xxx-xxxx_	
Date: _Nov 19/18_	
Prescriber Address for orders for narcotics, controlled substances, benzodiazepines, and gabapentin	

CONFIDENTIALITY NOTICE: The content of the communication is confidential and contains personal health information. It is intended solely for the use of the patient's health care providers. If you have received this communication in error, immediately notify the sender by return fax and destroy all originals and copies of the misdirected communication.

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TEST PATIENT

Age:	76 yrs	HSN:	888888888
DOB:	20/06/1942	MRN#:	000123456
Gender: <None>		Admitted: Nov 14, 2017	

1. Active Inpatient Medications (continued)
Review MAR and prescriber order sheets for last 72hrs

Scheduled medications, followed by PRN active prior to discharge

Prescriber Orders
Also add written quantity for narcotics, controlled substances, benzodiazepines, and gabapentin

Medication	Dose / Route / Frequency	Same as prior to admission	Adjusted in hospital	New in hospital	Comments / Rationale / Indication	Continue	Quantity Discharge Only	Refills Discharge Only	No Rx Needed	STOP
ACETAMINOPHEN tab 325 mg	650 MG (2 TAB) PO *OR NG/PR* Q4H PRN			✓	PPO		☐ ½₁₂ Or			✓
METOCLOPRAMIDE tab 5 mg (METONIA)	10 MG (2 TAB) PO *OR NG/IV* Q6H PRN			✓	PPO		☐ ½₁₂ Or			✓
ANTACID (MAGNESIUM/ALUMINUM) SUSP 350 mL	15 TO 30 ML PO PRN			✓	PPO		☐ ½₁₂ Or			✓
dimenhyDRINATE TAB 50 MG	12.5 TO 50 MG PO Q4H PRN *OR NG/PR/IV* Q4H PRN (CONSIDER LOWER DOSE FOR FRAIL/ELDERLY)			✓	PPO		☐ ½₁₂ Or			✓
ONDANSETRON TAB 4 MG	4 MG (1 TAB) PO *OR NG/IV* Q8H PRN (NON-SEDATING) **DISCONTINUE ON DISCHARGE**			✓	PPO		☐ ½₁₂ Or			✓

Medications Ordered After Time of Printing:

Medication						Continue	Quantity	Refills	No Rx Needed	STOP
Zoplicone 5 mg po HS				✓		✓	☐ ½₁₂ Or			
							☐ ½₁₂ Or			
							☐ ½₁₂ Or			
							☐ ½₁₂ Or			
							☐ ½₁₂ Or			
							☐ ½₁₂ Or			

Completed by: _Nurse A_ Title _RN_
Date: _NOV 19/18_ Time: _1400_

Reviewed by: _Nurse B_ Title _RN_
Date: _Nov 19/18_ Time: _1830_

Authorized Prescriber: #: _____
Physician (print)
Physician (sign)
Phone #: _xxx - xxx - xxxx_
Date: _Nov 19/18_
Prescriber Address for orders for narcotics, controlled substances, benzodiazepines, and gabapentin

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SK Discharge/Transfer Medication Reconciliation Form
Saskatchewan Health Authority

Location: SHA YRH ICUS

TEST PATIENT

Age:	76 yrs	HSN:	888888888
DOB:	20/06/1942	MRN#:	000123456
Gender: <None>		Admitted: Nov 14, 2017	

2. Pre-admission medications as listed on Best Possible Medication History			Prescriber Orders				
			Also add written quantity for narcotics, controlled substances, benzodiazepines, and gabapentin				
RESTART pre-admission medications not ordered or stopped in hospital STOP pre-admission medications no longer required		Comments / Rationale / Indication	Restart	Quantity Discharge Only	Refills Discharge Only	No Rx Needed	STOP
Medication	Dose / Route / Frequency						
Amitriptyline	10mg po daily	Stopped on admission	✓	☐ ½12 Or			
Amlodipine	5mg po daily	Stopped on admission		☐ ½12 Or			✓
				☐ ½12 Or			
				☐ ½12 Or			
				☐ ½12 Or			
				☐ ½12 Or			
				☐ ½12 Or			
				☐ ½12 Or			
				☐ ½12 Or			

Completed by: _____ Nurse A _____ Title RN
Date: NOV 19/18 Time: 1400

Reviewed by: _____ Nurse B _____ Title RN
Date: Nov 19/18 Time: 1830

Authorized Prescriber:	#: _____
Physician	
Physician	(print)
Physician	(sign)
Phone #: xxx-xxx-xxxx	
Date: Nov 19/18	
Prescriber Address for orders for narcotics, controlled substances, benzodiazepines, and gabapentin	

Version: BDM.2.11   Printed on: 2018-Nov-19 at 08:39:12 with job id#:40996245   Page 3 of 4

SK Discharge/Transfer Medication Reconciliation Form
Saskatchewan Health Authority

Location: SHA YRH ICUS

TEST PATIENT			
Age:	76 yrs	HSN:	888888888
DOB:	20/06/1942	MRN#:	000123456
Gender: <None>		Admitted: Nov 14, 2017	

3. NEW medications to START after discharge

			Prescriber Orders Also add written quantity for narcotics, controlled substances, benzodiazepines, and gabapentin	
Medication	Dose / Route / Frequency	Comments / Rationale / Indication	Quantity Discharge Only	Refills Discharge Only
			☐ ½₂ Or	
			☐ ½₂ Or	
			☐ ½₂ Or	
			☐ ½₂ Or	
			☐ ½₂ Or	
			☐ ½₂ Or	
			☐ ½₂ Or	

Other Medication Instructions/Comments:

Copied/Faxed to:	Name of Recipient / Fax #	Date	Copied/Faxed to:	Name of Recipient / Fax #	Date
☐ Community Pharmacy			☑ Receiving Facility	New Hospital 123-456-7890	Nov 19/18
☐ Long Term Care			☐ Family Physician/ Nurse Practitioner		
☐ Home Care			☐ Other ☐ Copy to patient		

Please note: If faxed to Community Pharmacy, stamp original FAXED and retain in chart.

Completed by: Nurse A   Title RN
Date: Nov 19/18   Time: 1400

Reviewed by: Nurse B   Title RN
Date: Nov 19/18   Time: 1830

Authorized Prescriber:	#:_____
	(print)
Phone #:	(sign)
Date:	
Prescriber Address for orders for narcotics, controlled substances, benzodiazepines, and gabapentin	

Version: BDM.2.11   Printed on: 2018-Nov-19 at 08:39:12 with job id#:40996245   Page 4 of 4

D. DTMR Discharge prescription Form (Paper version)

SK Discharge/Transfer Medication Reconciliation Form
Saskatchewan Health Authority
Location: _Indian Head Union Hospital_

Tonne, Clay   HSN: 123 456 789
Age: 66 years   MRN#: 987 654
DOB: 03/03/1951   Admitted: Nov 1, 2017
Gender: M   Label/Address

123 Easy street
Indian Head, SK, xxx xxx

Allergies:
Codeine

Prescription - Discharge to Home ☑
Prescription - Discharge to LTC ☐
Transfer Medication List - External ☐
Transfer Orders - Internal ☐

Community Pharmacists: For refills beyond what is listed below, please contact family physician/nurse practitioner.

1. Active Inpatient Medications
Review MAR and prescriber order sheets for last 72hrs

Medication	Dose / Route / Frequency	Same as prior to admission	Adjusted in hospital	New in hospital	Comments / Rationale / Indication	Continue	Quantity (Discharge Only)	Refills (Discharge Only)	No Rx Needed	STOP
Warfarin TAB 1MG	1MG (1 TAB) PO DAILY Sched: 16:00	✓			Last dose – May 6 at 4pm	✓	☐ ½ 7 days			
RAMIPRIL CAP 5MG	5MG (1 CAP) PO DAILY Sched: 09:00		✓		↑ from 2.5mg Last dose – May 7 at 9am	✓	☑ ½ Or			
FLUOXETINE CAP 40 MG	40 MG (1 CAP) PO DAILY Sched: 09:00	✓			Follow up with Psychiatrist in 2 weeks. Last dose –	✓	☐ ½ Or		✓	
					May 7 at 9am		☐ ½ Or			
RANITIDINE	150 MG PO BID Takes at 09:00 and 21:00		✓			✓	☑ ½ Or			
PRN Medications:							☐ ½ Or			
Acetamophen Tab	325 MG (1 TAB) PO PRN		✓				☐ ½ Or			✓
DimenhydrINATE Tab	50 MG (1 TAB) PO PRN		✓				☐ ½ Or			✓
(or may give IV – see alternate order)							☐ ½ Or			
							☐ ½ Or			
							☐ ½ Or			
							☐ ½ Or			

Completed by: Dinsh Might   RN
Date: Nov 4, 2017   Time: 14:00

Reviewed by: Snow White   RN
Date: Nov 4, 2017   Time: 15:45

Authorized Prescriber: #: 123456
Dr All Better
AlBe   (print)
   (sign)
Phone #: xxx – xxx – xxx
Date: Nov 4/17
1234 Any street, Indian Head Union Hospital, Indian Head, SK

Version: Paper.2.11

Page 1 of 3

SK Discharge/Transfer Medication Reconciliation Form
Saskatchewan Health Authority
Location: _Indian Head Union Hospital_

Tonne, Clay
Age: 66 years   HSN: 123 456 789
DOB: 03/03/1951   MRN#: 987654
Gender: M   Admitted: Nov 1, 2017

Label/Address
123 Easy Street, Indian Head, SK, XXX XXX

2. Pre-admission medications as listed on Best Possible Medication History		Comments / Rationale / Indication	Prescriber Orders Also add written quantity for narcotics, controlled substances, benzodiazepines, and gabapentin				
RESTART pre-admission medications not ordered or stopped in hospital STOP pre-admission medications no longer required			Restart	Quantity Discharge Only	Refills Discharge Only	No Rx Needed	STOP
Medication	Dose / Route / Frequency						
APO-Furosemide Tab	20MG(1 TAB) PO BID	Held in hospital		☐ ½ Or			✓
	Sched: 09:00, 12:00			☐ ½ Or			
				☐ ½ Or			
				☐ ½ Or			
				☐ ½ Or			
				☐ ½ Or			
				☐ ½ Or			
				☐ ½ Or			
				☐ ½ Or			
				☐ ½ Or			
				☐ ½ Or			
				☐ ½ Or			
				☐ ½ Or			
				☐ ½ Or			
				☐ ½ Or			
				☐ ½ Or			

Completed by: _Discharge Might_   RN
Date: _Nov 4, 2017_   Time: _14:00_

Reviewed by: _Snow White_   RN
Date: _Nov 4, 2017_   Time: _15:45_

Authorized Prescriber:	#: 123456
Dr All Better	
AllBe	(print)
Phone #: XXX - XXX - XXX	(sign)
Date: Nov 4/17	
1234 Any Street, Indian Head Union Hospital, Indian Head, SK	

Version: Paper.2.11

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SK Discharge/Transfer Medication Reconciliation Form
Saskatchewan Health Authority
Location: _Indian Head Union Hospital_

3. NEW medications to START after discharge			Prescriber Orders Also add written quantity for narcotics, controlled substances, benzodiazepines, and gabapentin	
Medication	Dose / Route / Frequency	Comments / Rationale / Indication	Quantity Discharge Only	Refills Discharge Only
Tylenol #3	1-2 tabs q 4h prn for pain	Ten tabs	☐½ or 10 tabs	
			☐½ Or	
			☐½ Or	
			☐½ Or	
			☐½ Or	
			☐½ Or	
			☐½ Or	

Other Medication Instructions/Comments:

Copied/Faxed to:	Name of Recipient / Fax #	Date	Copied/Faxed to:	Name of Recipient / Fax #	Date
☑ Community Pharmacy	Drugs R' us 555-555	Nov 4 2017	☐ Receiving Facility		
☐ Long Term Care			☑ Family Physician/ Nurse Practitioner	Dr Trixie 555-0000	Nov 4/17
☐ Home Care			☐ Other ☑ Copy to patient	Tonne, Clay	Nov 4/17

Please note: If faxed to Community Pharmacy, stamp original FAXED and retain in chart.

Completed by: Dinah Might   RN
Date: Nov 4, 2017   Time: 14:00

Reviewed by: Snow White   RN
Date: Nov 4, 2017   Time: 15:45

Authorized Prescriber:	#: 123456
Dr All Better	
ALBe	(print)
Phone #: XXX-XXX-XXX	(sign)
Date: Nov 4/17	
1234 Any street, Indian Head Union Hospital, Indian Head, SK	

Version: Paper.2.11

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