Medication Review: Action Plan

Date of Review: ______________________________

Pharmacist Name: ______________________________

Doctor Name: ______________________________

Medication Use Issue	Proposed Action	Action by	Outcome, if known, with dates

Patient:

- ☐ This is your copy; please retain it for your personal use. You may wish to share it with other health care professionals.
- ☐ Please make an appointment with your doctor to discuss within___ weeks
- ☐ Take this form to your next scheduled doctor appointment
- ☐ Follow actions agreed to above

Doctor:

- ☐ This is your copy; please retain a copy in your patient's notes
- ☐ For information only – no action required
- ☐ Please review the actions proposed above