DOCTORS STAMP

Referral for Medical Benefits Schedule Item 903
To EHS/WardMM/Mederev, kindly conduct a collaborative RMMR for

Resident Name:	**Doctors Name:**
Date of Birth:	**Provider Number:**
Date of Last Review:	Doctors Email:
Facility:	Doctors Fax:

Pharmacist Notes:

1. Reasons for referral for RMMR (tick at least one):

- ☐ A. New Admission
- ☐ B. Discharge from hospital after an unplanned admission in the previous 4 weeks
- ☐ C. Presentation of symptoms suggestive of an adverse drug reaction
- ☐ D. Sub-therapeutic response to treatment or significant change in medication regimen use of a medicine with a narrow therapeutic index or requiring therapeutic monitoring
- ☐ E. Usage of high-risk medications including psychotropic drugs, anticoagulants, hypoglycaemic agents, potent analgesia or other related drugs
- ☐ F. Change in medical condition or abilities - *this may include potentially medication related geriatric syndromes including but not limited to…* [circle any that apply]

• dizziness/falls/gait problems	• weight loss or weight gain	• difficulty swallowing
• bladder control problems	• sleep problems	• pressure ulcers
• change in cognition/behaviour	• no longer able to self-medicate	• changes in therapeutic objectives

- ☐ G. Other (incl. polypharmacy) – add comments below

2. Doctor Comments

Doctor Signature: …… **Date:**

List of current medications, CMA, progress notes, blood tests and resident's consent are available at the aged care facility.
This referral has been made as the review is deemed to be clinically necessary.

Please return signed form via email to referral@embeddedhealth.com.au or alternatively fax to **03 8678 3299**