<PracticeLetterhead>

Referral for Domiciliary Medication Management - Home Medicines Review

Medical Benefits Schedule Item 900. Also known as DMMR or HMR

Patient	**Credentialed Pharmacist or Community Pharmacy**	**Referring General Practitioner**
<PtDetails> **DOB:** <PtDoB> **Phone Number:** <PtPhoneMob> <PtPhoneH> **Medicare / DVA Number:** <PtMCNo> <PtDVANo> <PtDVACard> **Medicare Ref:** <PtMCLine> **Contact Details:** <Contact details (if person other than patient is required to arrange appointment)>	<AdrDetails> **Email:** <AdrEmail>	<DrName> <DrAddress> **Provider Number:** <DrProviderNo> **Phone Number:** <DrPhone> **Email:** <PracEmail>

<FormattedDate>

Dear Pharmacist,

Please conduct a Home Medicines Review / DMMR for <PtFullName>. I have included their medical history, current medications, pathology results and additional information relevant to the Medication Review.

The patient <Speaks English> and an interpreter <interpreter is required>. The patient's preferred language is <Preferred language>

Reason for DMMR Referral:
<Reason for DMMR referral: select all applicable>
<Reason for DMMR referral: Other please specify>

Personal Goals and Preferences:
<Personal Goals and Preferences>

Allergies/Adverse Reactions
<Reactions>

Medical History:
<PMHAll>

Current Medications
<CurrentRx>

Immunisations
<Imm>

Measurements
<Observations>

Ethnicity:
<PtEthnicity>

Family History:
<FamilyHx>

Social History:
<SocialHx>

Issue that may influence medication use:
<Issue that may influence medication use: select all applicable>
<Issue that may influence medication use: Other please specify>

Aids or other equipment used:
<Aids or other equipment used: select all applicable>
<Aids or other equipment used: Other please specify>

Relevant Pathology Results
<Ix>

I HAVE EXPLAINED TO THE PATIENT

<I HAVE EXPLAINED TO THE PATIENT: the process in having a DMMR; and> the process in having a DMMR; and

THE PATIENT UNDERSTANDS THAT:

<THE PATIENT UNDERSTANDS THAT: the DMMR interview must occur face to face at the patient's home unless there are exceptional circumstances. Approval to conduct a DMMR at an alternative location must be ontained in advance; and> the DMMR interview must occur face to face at the patients own home, unless there are exceptional circunstances. Approval to conduct a DMMR at an alternative location must be obtained in advance.

<THE PATIENT UNDERSTANDS THAT: the pharmacist who will conduct the DMMR will communicate with me information arising from the DMMR; and> the pharmacist who will conduct the DMMR will communicate with me information arising from the DMMR; and

THE PATIENT HAS CONSENTED:

<THE PATIENT HAS CONSENTED: to me releasing to you information about their medical history and medications; and> to me releasing to you information about their medical history and medications; and

THE PATIENT HAS CONSENTED:

<Consent to release Medicare/DVA number> to me releasing their Medicare no. or DVA no. to you for the pharmacist's payment purposes.

Signed..... Date:
<DrName>
<DrQualifications>
Provider Number: <DrProviderNo>