Ontario

Ministry of Health
and Long-Term Care

MedsCheck

MedsCheck Patient Acknowledgement of Professional Pharmacy Service

To be completed annually for MedsCheck Professional Pharmacy Services (excluding MedsCheck for Long-Term Care Home residents).

Patient Information

Last Name

First Name

Unit Number

Street Number

Street Name

PO Box

City/Town

Province

Postal Code

Telephone Number

Email Address (if available)

Pharmacy Information

Pharmacy Name

Unit Number

Street Number

Street Name

PO Box

City/Town

Province

Postal Code

Telephone Number

Fax Number

Email Address (if available)

Professional Pharmacy Services

MedsCheck reviews typically occur at the pharmacy where there is a sufficient level of privacy that ensures patient confidentiality.

☐ MedsCheck Annual ☐ MedsCheck Follow-up ☐ MedsCheck for Diabetes Annual ☐ Diabetes Education Follow-up

☐ MedsCheck at Home (also includes a medication cabinet clean-up and pharmacist disposal of unused medication from the patient home, where applicable)

Patient Acknowledgement

By signing this form, you are acknowledging participation in an in-person MedsCheck medication review with a pharmacist and that the MedsCheck program information has been explained to you.

Patient / Agent Signature

Date (yyyy/mm/dd)

Comments