New Choices Waiver

Medication Management Review

Name: _____ DOB: _____ Medicaid ID: _____

The medication management review should correspond with the MDS-HC assessment. Anytime a new MDS-HC assessment is required, a new Medication Management Review form should also be filled out. A quarterly Medication Management Review should take place every three months following the MDS-HC (i.e. January, April, July, and October).

Attach a current, complete list of the client's medications as of the date of the assessment. This list should include the medication name, associated diagnosis, dose, route and frequency.

Corresponding MDS-HC Assessment Date: _____

Who is responsible for administering medications? ☐ Facility Staff ☐ Client ☐ Other_____

If the facility staff is responsible for administering medications, was the Medication Administration Record (MAR) for the past three calendar months reviewed? ☐ Yes ☐ No

Concerns related to Medication Administration or Compliance: ☐ N/A

Potential Medication Interactions Identified: ☐ N/A

Does the client receive laboratory testing to monitor therapeutic levels of any medications listed? ☐ Yes ☐ No

If yes, please describe the services in place to provide this testing. Identify any issues or potential issues that have occurred over the past three calendar months**.**

Document follow- up that occurred (including outcomes) with the prescribing physician, the facility, or the client to address any concerns identified above.

The undersigned is not responsible for administering or prescribing medications. This form has been completed based on the clinical knowledge and judgment of the RN.

RN Name: _____ Signature: _____ Date: _____

New Choices Waiver

Medication Management Review

Quarterly Reviews

The quarterly review will identify any changes in the medication regimen, concerns that are ongoing or not previously identified, and follow-up that occurred (including outcomes) with the prescribing physician, the facility, or the client to address the concerns identified.

Quarter 1 Review (3 months following MDS-HC)

RN Name: _____ Signature: _____ Date: _____

Quarter 2 Review (6 months following MDS-HC)

RN Name: _____ Signature: _____ Date: _____

Quarter 3 Review (9 months following MDS-HC)

RN Name: _____ Signature: _____ Date: _____