Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

*Attach a current, complete list of the individual’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 [ ]  NCW Individual [ ] 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 individual 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 individual 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: \_\_\_\_\_\_\_\_\_\_\_\_

**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 individual to address the concerns identified.

**Second Quarter Review** (3 months following the most recent MDS-HC)

RN Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Third Quarter Review** (6 months following the most recent MDS-HC)

RN Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Fourth Quarter Review** (9 months following the most recent MDS-HC)

RN Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_