**Community Monitored Dosage System Suitability Assessment**

**Issue Date:** November 2016 **Review:** November 2018

Patient: Date of Birth:

Address:

Date of Assessment:

INFORMATION PROVIDED BY PATIENT/REPRESENTATIVE

Please provide name and contact details if information is provided by the patient’s representative

Name: Tel:

Address:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Situations to be considered** | **Suggested questions** | **Patient’s response** | **Suggested Options** | **Recommendation** |
| Is the patient finding it difficult to cope with routines? | Do you sometimes forget to take your medicines? Do you have any routines to help you to remember to take your medicines? |  | Consider MAR Chart or MDS System |  |
| Can patient self-administer medication from the MDS system? (consider physical and mental capabilities) | Do you have any problems opening or closing your medication containers? Do you have any problems getting medicines out of the container? |  | Ask patient to try with MDS to see if suitable during assessment. If patient cannot administer medication themselves, inform GP and consider an alternative arrangement e.g. carer |  |
| Is the patient taking any medication that is unsuitable to dispense in MDS? | Can you take or use all of your medicines? (Any soluble tablets, drops or inhalers) |  | Consider MAR chart or alternative arrangement e.g. carer |  |
| Can the patient read the dosage instructions on the label? | Could the instructions on your medicines be improved to help you manage them better? |  | Consider using larger print on the label. Inform patients GP of the concern and consider an alternative arrangement. MDS may not be suitable |  |
| Is patient taking a lot of “when required medication? | How many of your prescribed medicines are supposed to be taken or used only when you need them |  | Explain to the customer that “when required” medication will not be dispensed in an MDS. Consider a MAR chart |  |

**Community Monitored Dosage System Suitability Assessment continued...**

Is Community MDS suitable for this patient: Yes [ ] No [ ]

Reasons and Summary of actions:

Pharmacist’s Name:

Registration No:

Signature: Date:

If MDS **IS** suitable for this patient, please complete the following documents:

•Monitored Dosage System Patient Record Card (SOP 11 Appendix 6)

•Monitored Dosage System Contact Details (SOP 11 Appendix 7)

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