PHARMACY USE ONLY

CACP/SMMA Care Plan Eligibility Checklist

RESIDENT NAME: _____ AHC#_____

Please confirm the following with each Resident prior to initiating a service for a CACP or an SMMA.

1. Has a Physician Comprehensive Care Plan, CACP or SMMA been completed for this resident in the past?	☐ Yes ☐No
2. If you answered Yes to Question 1, obtain a copy for the patient record. Did you attempt to obtain a copy?	☐ Yes ☐No

Resident Eligibility:

3. Is the resident currently registered with the **Alberta Health Care Insurance Plan**?	☐ Yes ☐No

To qualify for a CACP, this resident must have either:
- ☐ Two Chronic Diseases from Column A; or
- ☐ One Chronic Disease from Column A and one Risk Factor from Column B.

To qualify for an SMMA, this resident must have:
- ☐ One chronic disease from Column A and be taking THREE or more different Schedule 1 medications.

To qualify for a Diabetes SMMA, this resident must have:
- ☐ Diabetes Mellitus and be taking
- ☐ Insulin or ONE or more Schedule 1 medications.

A Diabetes SMMA Assessment CANNOT be claimed if the resident has already received A CACP or SMMA.

To qualify for a Tobacco Cessation SMMA, this resident must:
- ☐ Use a tobacco product daily, and
- ☐ Be willing to receive tobacco cessation counseling and support, including pharmacotherapy at this time.

Maximum of four Tobacco Cessation Followups /365 days.

May be claimed in addition to a CACP, SMMA or Diabetes SMMA.

Chronic Diseases (Column A)			Risk Factors (Column B)
☐ **Hypertension**	☐ **COPD**	☐ **Angina Pectoris**	☐ **Obesity** (BMI > or = 30)
☐ **Diabetes Mellitus**	☐ **Asthma**	☐ **Other Chronic Ischemic Heart Disease**	☐ **Addictions**
	☐ **Heart Failure**		☐ **Tobacco**
Mental Disorders*			
☐ Anxiety	☐ Depression	☐ Panic	
☐ ADD/ADHD	☐ Eating Disorders	☐ Paranoia	
☐ Autism	☐ Hallucinations	☐ Personality Disorder	
☐ Bipolar	☐ Insomnia (see exclusions)	☐ PTSD	
☐ Dementia	☐ OCD	☐ Schizophrenia	
☐ Other: _____			

*ICD-9 Codes 290-319, excluding 303, 304, 305.1

* For full listing and exclusions see http://www.health.alberta.ca/documents/Diagnostic-Code-ICD-9.pdf

*Each individual qualifying mental disorder code counts as one chronic disease

PHARMACY USE ONLY

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Pharmacy Name and/or Logo	*[INSERT Pharmacy Name and/or Logo]*	Page x of y pages	
Pharmacy Address	*[INSERT Pharmacy Address]*	Prepared by	*pharmacist name, Practice Permit#*
Pharmacy Phone/Fax Number	*[INSERT Pharmacy Phone/Fax Number]*	Prepared on:	*date (dd-mm-yyyy)*

Resident Information and Eligibility

Select One:

ANNUAL		FOLLOWUP	
☐ CACP	☐ Diabetes SMMA	☐ CACP	☐ Diabetes SMMA
☐ SMMA	☐ Tobacco Cessation SMMA	☐ SMMA	☐ Tobacco Cessation SMMA

Resident Information

Name:

Address: **Phone:**

AB Health Care Card #:

Date of Birth: **Gender: M / F**

Substitute Decision Maker Information (if applicable)

Name:

Address: **Phone:**

Current Medical Conditions

- ☐ **Acne**
- ☐ **Addictions:** _____
- ☐ **Allergic Rhinitis**
- ☐ **Anemia**
- ☐ **Aneurism**
- ☐ **Angina Pectoris (IHD)**
- ☐ **Anxiety**
- ☐ **Asthma**
- ☐ **Attention Deficit Disorder (ADD/ADHD)**
- ☐ **Benign Prostatic Hyperplasia**
- ☐ **Bipolar**
- ☐ **Cancer:** _____
- ☐ **Chronic Kidney Disease**
- ☐ **Chronic Liver Disease**
- ☐ **Chronic Obstructive Pulmonary Disease**
- ☐ **Constipation**
- ☐ **Crohn's**
- ☐ **Dementia**
- ☐ **Depression**
- ☐ **Diabetes Mellitus**
- ☐ **Diarrhea**
- ☐ **Dysrhythmia**
- ☐ **Dyspepsia and Peptic Ulcer**
- ☐ **Eating Disorder**
- ☐ **Eczema**
- ☐ **GERD**
- ☐ **Glaucoma**
- ☐ **Gout**
- ☐ **Hemorrhoids**
- ☐ **Hypertension**
- ☐ **Hyperlipidemia**
- ☐ **Inflammatory Bowel Disease**
- ☐ **Insomnia**
- ☐ **Irritable Bowel Syndrome**
- ☐ **Ischemic Heart Disease (IHD), Other Chronic**
- ☐ **Lower Urinary Tract Symptoms**
- ☐ **Macular Degeneration**
- ☐ **Menopause**
- ☐ **Migraine**
- ☐ **Myocardial Infarction:** _____
- ☐ **Multiple Sclerosis (MS)**
- ☐ **Neuropathy**
- ☐ **Obesity (BMI > or = 30)**
- ☐ **Obsessive Compulsive**
- ☐ **Osteoarthritis**
- ☐ **Osteoporosis**
- ☐ **Pain:** _____
- ☐ **Parkinson's Disease**
- ☐ **Post Cataract Surgery**
- ☐ **Osteoarthritis**
- ☐ **Osteoporosis**
- ☐ **Psoriasis**
- ☐ **Rheumatoid Arthritis**
- ☐ **Schizophrenia**
- ☐ **Seasonal Allergies**
- ☐ **Seizures**
- ☐ **Sexual Dysfunction**
- ☐ **Smoking Cessation**
- ☐ **Stroke/TIA**
- ☐ **Thyroid (Hyper / Hypo)**
- ☐ **Tobacco Use**
- ☐ **Ulcerative Colitis**
- ☐ **Urinary Incontinence**

Other Medical Conditions:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

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Pharmacy Phone/Fax Number	*[INSERT Pharmacy Phone/Fax Number]*	Prepared on:	*date (dd-mm-yyyy)*

Best Possible Medication History

Resident Information

Name:

Address: **Phone:**

AB Health Care Card #:

Date of Birth: **Gender:** **M / F**

Allergy/Intolerance

Drug/Substance:

☐ rash ☐ shock ☐ nausea ☐ vomiting ☐ other _____

☐ rash ☐ shock ☐ nausea ☐ vomiting ☐ other _____

☐ rash ☐ shock ☐ nausea ☐ vomiting ☐ other _____

☐ rash ☐ shock ☐ nausea ☐ vomiting ☐ other _____

Lifestyle

Tobacco Use?
☐ Yes ☐No
☐ 10 or less
☐ 11–20
☐ 21–30
☐ > 31

Alcohol Use?
☐ Yes ☐No
☐ < 2 drinks/week
☐ 2-6 drinks/week
☐ > 6 drinks/week
☐ History of alcohol dependence

Caffeine Use?
☐ Yes ☐No
☐ < 2 cups/day
☐ 2-6 cups/day
☐ > 6 cups/day
☐ History of caffeine dependence

Other Recreational Drug Use?
☐ Yes ☐No

Height _____ cm / _____ feet _____ inches **Weight** _____kg / _____ lbs _____ oz

If Female: Pregnancy (Date Due) **Breastfeeding? ☐ Yes ☐No**

Aids/Alerts/Devices/Other Health Information

A copy of this form to be provided to the patient.

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Pharmacy Phone/Fax Number	*[INSERT Pharmacy Phone/Fax Number]*	Prepared on:	*date (dd-mm-yyyy)*

Best Possible Medication History (Cont)

MEDICATIONS I TAKE
(Prescription, non-prescription, natural health products, vitamins)

WHAT I TAKE (Name, Strength, Dosage Form)	WHY I TAKE IT Indication/Condition	HOW I TAKE IT Directions	WHO PRESCRIBED IT	SPECIAL INSTRUCTIONS

A copy of this form to be provided to the patient.

Pharmacy Name and/or Logo	*[INSERT Pharmacy Name and/or Logo]*	Page x of y pages	
Pharmacy Address	*[INSERT Pharmacy Address]*	Prepared by	*pharmacist name, Practice Permit#*
Pharmacy Phone/Fax Number	*[INSERT Pharmacy Phone/Fax Number]*	Prepared on:	*date (dd-mm-yyyy)*

CONDITION PLAN AND INTERVENTION

(Complete One Form for each Condition and/or Drug Therapy Problem)

Indication/Medical Condition

Goal for Therapy

Assessment (Signs/Symptoms, Current Therapy, Relevant Lab Data*)	Drug Therapy Problem (DTP) Classification
	Date Identified: _____/_____/_____ ☐ **Unnecessary Therapy** ☐ **Needs Additional Therapy** ☐ **Different Drug Required** ☐ **Dose Too Low** ☐ **Adverse Drug Reaction** ☐ **Dose Too High** ☐ **Compliance** ☐ **No Drug Therapy Problems** for this condition at this time.

Recommended Change to Drug Therapy (include dose, frequency, route, duration)	Action to resolve DTP (check all that apply)
	☐ Initiate Drug Therapy ☐ Discontinue Drug Therapy ☐ Changed frequency of Admin ☐ Increase Dose ☐ Decrease Dose ☐ Provide Patient Education/Info ☐ Refer to Physician ☐ Refer to Other Health Care Prof. (Specify)_____

Monitoring Parameters - Safety/Efficacy, Required Lab Work (for this condition and/or intervention)	Recommended Follow up Schedule (for this condition and/or intervention)	
	☐ 7 days	☐ Every 3 Months
	☐ 14 days	☐ 6 months
	☐ 1 month	☐ Every 6 months
	☐ Monthly	☐ Annually
	☐ 3 months	☐ Other: (Specify)

***Attach relevant lab report data to this form if/when available.**

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Pharmacy Phone/Fax Number	*[INSERT Pharmacy Phone/Fax Number]*	Prepared on:	*date (dd-mm-yyyy)*

CARE PLAN NOTES

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Pharmacy Address	*[INSERT Pharmacy Address]*	Prepared by	*pharmacist name, Practice Permit#*
Pharmacy Phone/Fax Number	*[INSERT Pharmacy Phone/Fax Number]*	Prepared on:	*date (dd-mm-yyyy)*

FOLLOW-UP PROGRESS NOTES FOR THIS CONDITION / INTERVENTION

Indication/Medical Condition	
Follow-up Date	**PROGRESS NOTE** **(Note: For each new DTP, please complete a new *Condition Plan and Intervention* form)**

☐ I have personally seen or had a telephone encounter and conducted an Assessment on the above Resident for the purpose of preparing, documenting and reviewing this Updated CACP/Updated SMMA in accordance with the requirements set out in the Compensation Plan for Pharmacy Services.

Name of Pharmacist **Signature** **Day/Month/Year**

A copy of this form to be kept on file in the pharmacy pursuant to the Health Information Act.

Pharmacy Name and/or Logo	*[INSERT Pharmacy Name and/or Logo]*	Page x of y pages	
Pharmacy Address	*[INSERT Pharmacy Address]*	Prepared by	*pharmacist name, Practice Permit#*
Pharmacy Phone/Fax Number	*[INSERT Pharmacy Phone/Fax Number]*	Prepared on:	*date (dd-mm-yyyy)*

Declaration and Consent of Resident or Resident's Substitute Decision Maker (as applicable)

I hereby confirm that:

1. *I have reviewed and discussed this CACP/Updated CACP/SMMA/Updated SMMA with the Clinical Pharmacist who prepared it;*

2. *I understand and accept the goals and potential risks of the medication therapy as outlined in this CACP/Updated CACP/SMMA/Updated SMMA; and*

3. *I have been provided with a copy or summary of this CACP/Updated CACP/SMMA/Updated SMMA.*

Name of Resident	**Signature of Resident**	**Day/Month/Year**

Name of Substitute Decision Maker (if applicable)	**Signature of Substitute Decision Maker (if applicable)**	**Day/Month/Year (if applicable)**

Declaration of Clinical Pharmacist

I hereby confirm that:

☐ I have personally seen and conducted an Assessment on the above Resident for the purpose of preparing, documenting and reviewing this CACP/Updated CACP/SMMA/Updated SMMA in accordance with the requirements set out in the Compensation Plan for Pharmacy Services,

OR

☐ I have personally seen or had a telephone encounter and conducted an Assessment on the above Resident for the purpose of preparing, documenting and reviewing this Updated CACP/Updated SMMA in accordance with the requirements set out in the Compensation Plan for Pharmacy Services.

Yes / No

Name of Clinical Pharmacist	**Practice Permit Registration Number**	**Additional Prescribing Authority**

Signature	**Day/Month/Year**

A copy of this form to be kept on file in the pharmacy pursuant to the Health Information Act.