niagarahealth
Extraordinary Caring. Every Person. Every Time.

Best Possible Medication History (BPMH) CLARIFICATION Order Form

**** THIS IS NOT A COMPLETE LIST OF YOUR PATIENT'S HOME MEDICATIONS****
PLEASE REFER TO THE BPMH

Home Medication Clarification(s):				PRESCRIBER To Complete					
Medication Name Include Prescription and regularly taken OTC, PRN, vitamin, herbal	Dose	Route	Frequency	Continue	Discontinue	Hold	Change	Reason for Change/Hold/Discontinuation	MAR
Clarification required because medication was: ☐ wrong dose/route/frequency ☐ omitted ☐ not taken at home				○	○	○	○		☐
Clarification required because medication was: ☐ wrong dose/route/frequency ☐ omitted ☐ not taken at home				○	○	○	○		☐
Clarification required because medication was: ☐ wrong dose/route/frequency ☐ omitted ☐ not taken at home				○	○	○	○		☐
Clarification required because medication was: ☐ wrong dose/route/frequency ☐ omitted ☐ not taken at home				○	○	○	○		☐
Clarification required because medication was: ☐ wrong dose/route/frequency ☐ omitted ☐ not taken at home				○	○	○	○		☐
Clarification required because medication was: ☐ wrong dose/route/frequency ☐ omitted ☐ not taken at home				○	○	○	○		☐

Comments/Notes:

Source of Information: (at least two, one which includes the patient/caregiver):

☐ Patient/caregiver recall ☐ Medication vial(s)/blister pack ☐ Discharge summary ☐ MAR from another facility
☐ ClinicalConnect ☐ Family physician list ☐ Medication list ☐ Community pharmacy list

Completed by (print): ____________________ **Physician Name (print):** ____________________

Signature: ____________________ **Signature:** ____________________

Date: __________ *(ddmmyyyy)* **Time:** ________ *(hhmm)* **Date:** __________ *(ddmmyyyy)* **Time:** ________ *(hhmm)*

If additional forms are required, please fill in, page _____ of _____ .

Chart Copy – Do Not Destroy – Place in Physician Order Section

Scanned to Pharmacy: Yes ☐ or No ☐ Date Scanned: ________________ *(dd/mm/yyyy)*

ORD248

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