Medical Practitioner – Medication Service Handover Plan

New Referral: ☐ **Review of Client Plan:** ☐

This form is designed to be used by a Medical Practitioner when requesting that a personal care provider take on the task nominated.

Client Name:		**DOB:**	
Address:		**Client Record No:**	
Doctor Name:		**Date of Assessment:**	
Qualification:		**Organisation:**	

Assist with Medication task as follows:

	Application Instructions/Specific Comments
Name of product	
Where is it to be applied	
Quantity to apply	
Frequency of application and/or preferred time	
Special Instructions	
Please tick appropriate service provider for this medication: ☐ Suitable for nursing service ☐ Suitable for Community Care Worker	

Assistance with medication task as follows: Dose Administration Aid

Describe type of assistance and any specific requirements:

Eg: take tablets from blister pack, put in clients hand, observe while she takes them.

Medication to be taken at the following intervals and times:

☐ **Breakfast (am)** ☐ **Lunch (pm)** ☐ **Dinner (pm)** ☐ **Bedtime (pm)**

The personal care provider will endeavour to schedule the client visit at the required time but be aware that this may be affected by conditions outside of their control.

Pharmacy Name (if known): Phone No:

Length of time medication is required:

Commencement: Cease Date: ☐ OR

Continue Indefinitely: ☐ Yes ☐ No

Review of Medication Task: (medical practitioner to determine frequency of review)

By: .....

Date of review:

Signature of Doctor completing this form: .....

Please complete this form and send at the same time as the SCTT (other) referral tool to the personal care provider organisation