Ministry of Health

Drug Plan & Extended Benefits
2nd Floor – 3475 Albert St.
Regina, SK S4S 6X6

DATE: _____

# MEDICATION ASSESSMENT and COMPLIANCE PACKAGING REQUEST

***Only Home Care/Regional Mental Health Clients are eligible**
***Must be completed by the Home Care/Mental Health Assessor**

## PATIENT IDENTIFICATION

**HEALTH SERVICES NUMBER** _____

**NAME** _____

**DATE OF BIRTH** _____ **Male:** ☐ **Female:** ☐

## HOME CARE/MENTAL HEALTH INFORMATION

**The above named Home Care/Mental Health client requires Compliance Packaging Services based on Home Care Assessment or Mental Health Assessment.** ☐ **YES**

_____

_____

*Notes/Comments*

☐ **HOME CARE ASSESSOR** ☐ **MENTAL HEALTH ASSESSOR**

**NAME** _____

PLEASE PRINT

**SIGNATURE** _____ **DATE** _____

| Home Care/Mental Health Assessor to Complete | Pharmacist to Complete |
|---|---|
| **Region:** _____ PLEASE PRINT | **Pharmacist Name:** _____ PLEASE PRINT |
| **Position:** _____ PLEASE PRINT | **Pharmacy:** _____ PLEASE PRINT |
| **Phone Number:** _____ | **Phone Number:** _____ |
| **Fax Number:** _____ | **Fax Number:** _____ |
| PLEASE FAX REQUEST TO PHARMACY | PLEASE FAX REQUEST TO DRUG PLAN AND EXTENDED BENEFITS BRANCH @ 306-787-8679 |

## DRUG PLAN USE ONLY

**Fax Back Information:**