**Case #4 – Clinician**

* Be the Clinician taking a best possible medication history
* Use the space below to document your best possible medication history

**Today is October 20th.** You are going to seePatient Harry Vicentewho is a 48 year old patient with chronic history of lymphedema, frequent admissions for diuresis and leg pain presenting with increased lower extremity edema and pain.

You are working with a computer system that allows you access to ambulatory electronic medical record for this patient, and the computer provides you with the following information

**Past Medical History:**‎ Lower Extremity Edema, Asthma, Depression, Diabetes mellitus type 2, Hypertension‎‎‎, Chronic Pain, Gout

**Allergies:** penicillins – rash, and lisinopril – throat tightness

You have a list from the computer, as follows

|  |  |
| --- | --- |
| Allopurinol 100mg PO daily | Gabapentin 1200mg PO three times a day |
| Amlodipine 5mg PO daily | Hydrocodone 5mg + acetaminophen 325mg PO q6h PRN breakthrough pain |
| Citalopram 10mg PO daily | Metformin Extended Release 500mg PO daily |
| Clonidine 0.1mg PO QHS | Potassium Chloride Extended Release 20meq PO daily |
| Furosemide 60mg PO daily | Fluticasone Prop/Salmeterol 250mcg/50mcg 1 inhalation BID |

You can use the attached checklist of high performance behaviors and the supplied pocket guide to help you

**High Performance Behaviors**

• Asks the patient open-ended questions about what medications she or he is taking (i.e., doesn’t read the list and ask if it is correct)

• Uses probing questions to elicit additional information: non-oral meds, non-daily meds, PRN medications, non-prescription meds

• Uses other probes to elicit additional medications: common reasons for PRNs, meds for problems in the problem list, meds prescribed by specialists

• Asks about adherence

• Uses at least two sources of medications, ideally one provided by the patient and one from another “objective” source (e.g., patient’s own list and ambulatory EMR med list)

• Knows when to stop getting additional sources (e.g., if patient has a list or pill bottles and seems completely reliable and data are not that dissimilar from the other sources, and/or the differences can be explained)

• Knows when to get additional sources if available (e.g., if patient is not sure, relying on memory only or cannot resolve discrepancies among the various sources of medication information)

• When additional sources are needed, uses available sources first (e.g., pill bottles present). Then obtains pharmacy data. If the medication history is still not clear: obtains outpatient provider lists, pill bottles from home and/or other sources.

• Uses resources like Drugs.com to identify loose medications (i.e., for a bag of medications, not in their bottles, provided by a patient)

• Returns to patient to review new information, resolve all remaining discrepancies

• Gets help from other team members when needed

• Educates that patient and/or caregiver about the importance of carrying an accurate and up to date medication list with them