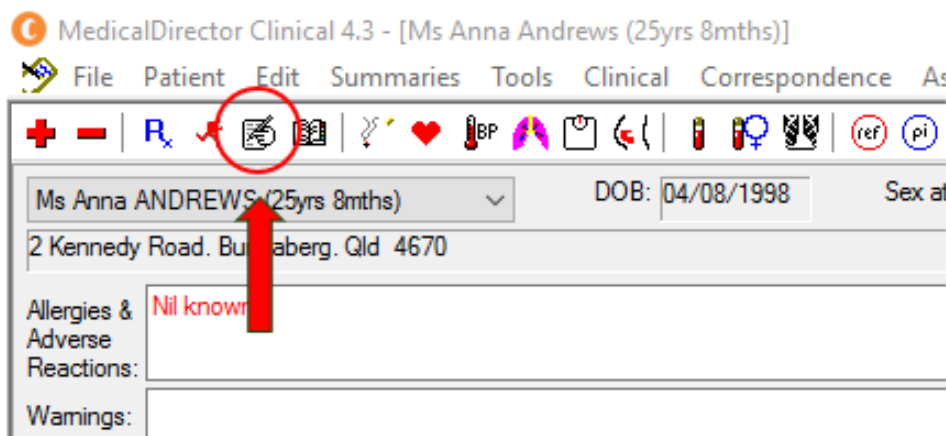


Creating a Medication Management Plan

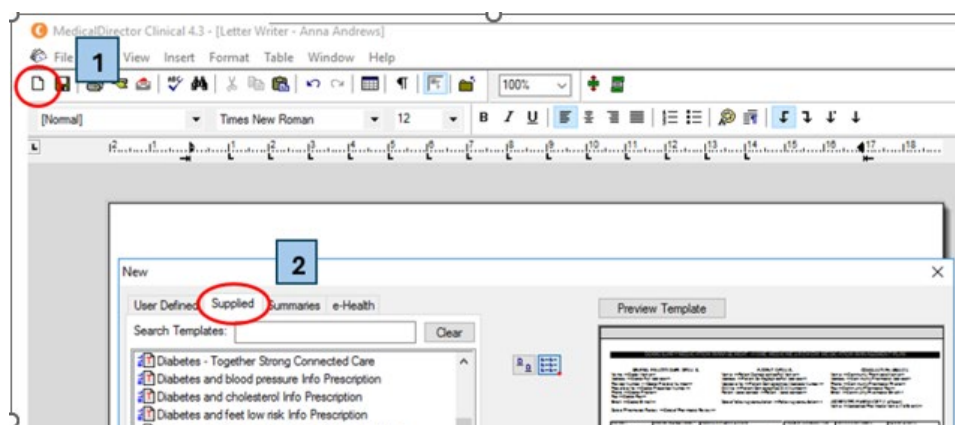
Medical Director

Claim Medicare Item 900 only after developing a **written Medication Management Plan (MMP)** in accordance with MBS requirements. This should involve a discussion with the patient about the HMR report findings and include agreed-upon goals and actions.

1. Open the **Patient Clinical File**.
2. Open **Letter Writer** by clicking on the Letter Writer Icon.



3. Select **New Template** Icon (1).
4. Select **Supplied** Template tab (2).



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Chermside QLD 4032
PO Box 2013 Chermside Centre QLD 4032
t 07 3630 7300

5. Select DMMR (Home Medicines Review) 2024.

User Defined Supplied Summaries e-Health

Search Templates: Clear

- Brisbane Clinical Neuroscience Centre Referral
- Bulk Bill Voucher DB4E
- Centrelink Medical Certificate (SU415)
- Centrelink Verification of Medical Conditions
- Chesterville Day Hospital Open Access Referral
- Comcare Certificate of Capacity
- COVID-19 Letter
- CRT Imaging Radiology Request
- DASS-21
- Dextropropoxyphene Prescriber Confirmation Form
- Diabetes and kidney disease Info Prescription
- DMMR (Home medicines review) 2024**
- DMMR Australia - (Home Medicine Review)
- DMMR Referral (Home medicines review)
- DVA Community Nursing Referral (D9389)

Filter
☐ Inc. all States

Currently Showing:

Preview Template

ORIGINAL PRESCRIPTION FORMULARY PATIENT DETAILS COMMUNITY PHARMACY

NAME: ADDRESS: PHONE: FAX: EMAIL: ACCREDITED PHARMACIST (if different):

DATE OF PHARMACIST REVIEW: DATE OF FOLLOW-UP CONSULTATION:

DATE	PHARMACIST	PHARMACIST'S COMMENTS	PHARMACIST'S SIGNATURE	PATIENT'S SIGNATURE	PATIENT'S DATE

6. Complete the **User Defined Fields**.

7. Include Credentialed (Accredited) Pharmacist name if different to Community Pharmacist name.

User Defined Fields

Enter the values for these fields:

Fields

Date of Pharmacist Review:

Patient / carer contact:

Follow-up consultation:

Community Pharmacist Name:

Community Pharmacist Address:

Community Pharmacist Phone:

Community Pharmacist Fax:

Community Pharmacist Email:

Accredited Pharmacist Name (if different):

OK Cancel

8. Select OK.

9. Complete the table ensuring all fields are filled and patient agrees to proposed plan of action.

Please note: To manually check a box, **backspace the box and press 'X' on the keyboard**. This will add a check box symbol.

CURRENT CONDITION/PROBLEM	CURRENT MANAGEMENT*	PROPOSED PLAN OF ACTION	PERSON RESPONSIBLE FOR ACTION**	EXPECTED OUTCOMES	PATIENT AGREES
		☐ No action required ☐ Action (comment):			
		☐ No action required ☐ Action (comment):			
		☐ No action required ☐ Action (comment):			
		☐ No action required ☐ Action (comment):			
		☐ No action required ☐ Action (comment):			

*pharmacological and/or non-pharmacological

** nominate other health care professional if applicable

10. Attach additional information as necessary.
11. Print, date, both parties sign completed documentation.
12. Offer a copy of the medication management plan to the patient.
13. Send a copy of the medication management plan to the Credentialed Pharmacist/Community Pharmacy and other relevant health professionals by chosen secure messaging method.
14. Claim MBS Item 900

Creating a Medication Management Plan

Medical Director – using a supplied template

GO TO:

PATIENT FILE



NEW LETTER



NEW TEMPLATE



SUPPLIED TEMPLATE



DMMR - (Home Medicines Review) 2024



DISCUSS HMR/DMMR FINDINGS WITH PATIENT



COMPLETE TABLE AND ISSUES IDENTIFIED



AGREE PROPOSED PLAN OF ACTION



OFFER COPY OF MMP TO PATIENT



SEND MMP TO CREDENTIALLED PHARMACIST/PHARMACY



CLAIM MBS ITEM 900

