DRAFT

Best Possible Medication Discharge Plan (BPMDP)

Discharge Date: _____

Allergies: _____

Primary Diagnosis: _____

Community Pharmacy: _____ Phone Number: _____

Patient Addressograph

To be completed by RPh , RN or MD Name: _____ Date_____								To be completed by MD			
Medications	**Dose**	**Route and Directions**	**Source (BPMH / MAR)**	**Same as prior to admission**	**Adjusted in hospital**	**Discontinued in hospital**	**New in hospital**	**Do Not Continue**	**Quantity**	**Repeats**	**Comments / Codes**
New Discharge Medications											

BPMDP Patient Interview Completed: ❑

Refer for *MedsCheck,* if patient is eligible: ❑

Physician (print name):_____ Physician's Signature:_____

Date: _____CPSO Number: _____

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