NHS
Essex Partnership University
NHS Foundation Trust

COMPLIANCE AID ASSESSMENT FORM

Name of patient:	NHS No:
Ward/unit:	Date of Birth:

Question	**Comment**
Does the patient normally use a monitored dosage system (MDS) in the community?	If no, what has changed necessitating the need for a MDS now?
Have there been any changes to regular medication?	If no, and the patient already has arrangements for MDS in community, there may be one already prepared. Contact regular community pharmacy
Is the medication regime stable?	Regimes which are likely to change now or in the near future are not suitable for MDS and a medication reminder sheet is more appropriate. Re-assess when medication regime stable if MDS still required, otherwise contact pharmacy for medication reminder sheet/education session
Is the patient being cared for by someone who is willing and able to administer medication?	If yes, has this person agreed/disagreed to undertake this task and are they competent to do so correctly.
Does the patient require a MDS because they have difficulty opening boxes/bottles or splitting tablets?	If yes, tablet cutters, larger bottles, screw caps and/or winged top lids are available from community pharmacies and a MDS may not be required
Is a MDS required because the patient has difficulty following printed instructions?	If print too small, larger labels may be available If difficulties in understanding instructions, has an education session been attempted with support of a medication reminder sheet/special labelling instructions? Contact a pharmacist for further support if necessary
Does the patient require a MDS because he/she is confused?	Has the medication regime been simplified to help adherence/concordance (doctor/pharmacist to complete) Has the patient been provided with a medication reminder sheet (available from pharmacy) to support the patient taking the right medicines at the right time?

If after reading through these questions and statements you still feel a patient requires a MDS, please give reasons below:

Date MDS required by: **Duration required:**

Form completed by (PRINT): **Date/time:** **Ext:**

Pharmacy

Date & time request received:

1. Does this patient require a MDS from a pharmacy? If no, what other compliance aid(s) have been provided to support compliance?

2. Are any of the medicines prescribed not suitable for removal from original container for the duration of the MDS supply? If so, what course of action has been taken to maintain efficacy of tablet whilst supporting patient concordance

3. Please detail a community pharmacy (including telephone/contact name) which has been identified (ideally patient's regular pharmacy) to continue providing compliance aid support?

Form Completed by: **Date:**

MDS completed by: **Date:**