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: