Pharm.D - Year 4

Clinical Pharmacy

Complete subject manual: 15 practicals and activities. Each chapter includes a student observation or work record.

Use the PDF bookmarks to navigate. The table gives each practical's content-page count; the combined manual has continuous page numbers.

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Drug-information Case 1 - Administration

Experiment 1 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Teaching scenario: A patient asks how to take a newly prescribed product.

Aim

To answer the assigned patient-specific drug-information question.

Principle

Question clarification and evidence appraisal connect medicine information with the intended clinical decision.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm exact medicine/formulation; authorised administration instructions; patient ability and practical barriers. Note missing information explicitly.

3. Develop the pharmacy assessment

Confirm the exact product rather than inferring instructions from the drug name. Prepare a plain-language explanation of administration, storage and missed-dose questions using the current authorised information. Ask the patient to explain the agreed plan back.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Coded query / deadline	_____
Clarified question	_____
Patient/product context	_____
Information checked and date	_____
Proposed answer / uncertainty	_____
Supervisor review / follow-up	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. Why collect patient-specific information?

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

Drug-information Case 2 - Interaction

Experiment 2 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Teaching scenario: The team asks whether two medicines can be used together.

Aim

To answer the assigned patient-specific drug-information question.

Principle

Question clarification and evidence appraisal connect medicine information with the intended clinical decision.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm complete regimen and indication; exposure and patient risks; current interaction evidence. Note missing information explicitly.

3. Develop the pharmacy assessment

Describe the proposed mechanism and likely consequence. Present the evidence, management options and monitoring for clinician review, distinguishing a potential alert from a confirmed clinically important event.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Coded query / deadline	_____
Clarified question	_____
Patient/product context	_____
Information checked and date	_____
Proposed answer / uncertainty	_____
Supervisor review / follow-up	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. Why collect patient-specific information?

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

Drug-information Case 3 - Suspected Adverse Effect

Experiment 3 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Teaching scenario: A new symptom occurs after a medicine change.

Aim

To answer the assigned patient-specific drug-information question.

Principle

Question clarification and evidence appraisal connect medicine information with the intended clinical decision.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm symptom chronology; medicine start/change dates; alternative explanations and seriousness. Note missing information explicitly.

3. Develop the pharmacy assessment

Create a dated timeline and assess the suspected relationship without claiming certainty. Identify urgent clinical concerns, communicate to the team and record the appropriate reporting and follow-up route.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Coded query / deadline	_____
Clarified question	_____
Patient/product context	_____
Information checked and date	_____
Proposed answer / uncertainty	_____
Supervisor review / follow-up	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. Why collect patient-specific information?

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

Drug-information Case 4 - Organ Function and Special Population

Experiment 4 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Teaching scenario: The team asks whether the current regimen needs review after a patient-specific risk changes.

Aim

To answer the assigned patient-specific drug-information question.

Principle

Question clarification and evidence appraisal connect medicine information with the intended clinical decision.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm renal/hepatic findings and trend; pregnancy/lactation or age context where relevant; current product-specific guidance. Note missing information explicitly.

3. Develop the pharmacy assessment

Identify the guidance that matches the medicine, formulation and patient situation. List the information still required and present a review request rather than automatically applying one dose rule to every medicine.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Coded query / deadline	_____
Clarified question	_____
Patient/product context	_____
Information checked and date	_____
Proposed answer / uncertainty	_____
Supervisor review / follow-up	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. Why collect patient-specific information?

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

Counselling Case 1 - New Medicine

Experiment 5 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Teaching scenario: A patient is starting an allocated medicine.

Aim

To counsel an allocated patient using an understandable, verified plan.

Principle

Counselling requires correct product-specific information, a conversation about barriers and confirmation of understanding.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm indication and authorised instructions; language, understanding and concerns; privacy and consent. Note missing information explicitly.

3. Develop the pharmacy assessment

Explain purpose, how to use the exact product, the prescribed schedule, relevant precautions and when/how to seek help. Ask the patient to explain the agreed plan in their own words and improve any unclear point.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Case / patient learning need	_____
Verified medicine/device plan	_____
Explanation / demonstration	_____
Teach-back finding	_____
Barrier and agreed action	_____
Follow-up	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. Why collect patient-specific information?

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

Counselling Case 2 - Inhaler Device

Experiment 6 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Teaching scenario: A patient demonstrates an assigned inhaler incorrectly.

Aim

To counsel an allocated patient using an understandable, verified plan.

Principle

Counselling requires correct product-specific information, a conversation about barriers and confirmation of understanding.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm exact inhaler model and prescribed use; device-specific demonstration checklist; privacy and consent. Note missing information explicitly.

3. Develop the pharmacy assessment

Identify the device type and use its authorised instructions with a training device. Demonstrate preparation, inhalation and after-use steps; ask for return-demonstration. Metered-dose and dry-powder devices have different technique requirements.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Case / patient learning need	_____
Verified medicine/device plan	_____
Explanation / demonstration	_____
Teach-back finding	_____
Barrier and agreed action	_____
Follow-up	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. Why collect patient-specific information?

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

Counselling Case 3 - Adherence Barriers

Experiment 7 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Teaching scenario: A patient reports missed doses.

Aim

To counsel an allocated patient using an understandable, verified plan.

Principle

Counselling requires correct product-specific information, a conversation about barriers and confirmation of understanding.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm actual medicine-taking pattern; cost, access, side effects and routine; privacy and consent. Note missing information explicitly.

3. Develop the pharmacy assessment

Ask without blame about practical barriers. Agree a feasible routine with the patient and supervisor, explain product-specific missed-dose advice from authorised information and arrange review of unresolved access or adverse-effect issues.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Case / patient learning need	_____
Verified medicine/device plan	_____
Explanation / demonstration	_____
Teach-back finding	_____
Barrier and agreed action	_____
Follow-up	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. Why collect patient-specific information?

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

Counselling Case 4 - Discharge Plan

Experiment 8 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Teaching scenario: A patient is leaving hospital with medicine changes.

Aim

To counsel an allocated patient using an understandable, verified plan.

Principle

Counselling requires correct product-specific information, a conversation about barriers and confirmation of understanding.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm verified discharge list and changes; follow-up and patient/caregiver ability; privacy and consent. Note missing information explicitly.

3. Develop the pharmacy assessment

Explain which medicines continue, start, change or stop according to the authorised plan. Check access, monitoring and follow-up, provide an understandable list and confirm understanding with teach-back.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Case / patient learning need	_____
Verified medicine/device plan	_____
Explanation / demonstration	_____
Teach-back finding	_____
Barrier and agreed action	_____
Follow-up	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. Why collect patient-specific information?

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

Laboratory Case 1 - Renal Findings

Experiment 9 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Teaching scenario: A coded record shows a changed creatinine and renal estimate.

Aim

To interpret a laboratory report in its clinical and medicine context.

Principle

Laboratory interpretation uses method-specific units and ranges, specimen validity, time trends and the overall clinical picture.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm creatinine/urea and renal-estimate method; timing, fluid context, baseline and current medicines; laboratory reference interval and any critical-result flag. Note missing information explicitly.

3. Develop the pharmacy assessment

Record the trend and the renal-estimate units/basis. Identify medicines requiring a product-specific review and communicate the change; do not assume eGFR and creatinine clearance are interchangeable for every dosing method.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Report / date / specimen	_____
Result / unit / local interval	_____
Previous result and trend	_____
Medicine-related review issue	_____
Escalation / supervisor decision	_____
Follow-up result	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. Why collect patient-specific information?

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

Laboratory Case 2 - Liver Findings

Experiment 10 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Teaching scenario: A coded record contains changed liver tests.

Aim

To interpret a laboratory report in its clinical and medicine context.

Principle

Laboratory interpretation uses method-specific units and ranges, specimen validity, time trends and the overall clinical picture.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm ALT/AST, ALP, bilirubin and relevant synthetic-function measures; baseline, dates, symptoms and medicine exposure; laboratory reference interval and any critical-result flag. Note missing information explicitly.

3. Develop the pharmacy assessment

Organise the pattern and trend rather than naming a disease from one result. Assess the temporal medicine link and alternative explanations, and request clinician review of the relevant safety findings.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Report / date / specimen	_____
Result / unit / local interval	_____
Previous result and trend	_____
Medicine-related review issue	_____
Escalation / supervisor decision	_____
Follow-up result	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. Why collect patient-specific information?

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

Laboratory Case 3 - Haematology Findings

Experiment 11 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Teaching scenario: A coded record contains a changed blood count.

Aim

To interpret a laboratory report in its clinical and medicine context.

Principle

Laboratory interpretation uses method-specific units and ranges, specimen validity, time trends and the overall clinical picture.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm haemoglobin, cells and differential where relevant; baseline, symptom and medicine chronology; laboratory reference interval and any critical-result flag. Note missing information explicitly.

3. Develop the pharmacy assessment

Use the laboratory-specific ranges, units and trend to identify the abnormal finding. Link it to possible treatment-monitoring concerns for review; a single count does not prove one cause.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Report / date / specimen	_____
Result / unit / local interval	_____
Previous result and trend	_____
Medicine-related review issue	_____
Escalation / supervisor decision	_____
Follow-up result	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. Why collect patient-specific information?

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

Laboratory Case 4 - Electrolyte Findings

Experiment 12 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Teaching scenario: A coded record contains an unexpected electrolyte result.

Aim

To interpret a laboratory report in its clinical and medicine context.

Principle

Laboratory interpretation uses method-specific units and ranges, specimen validity, time trends and the overall clinical picture.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm sodium/potassium and specimen-quality information; trend, symptoms, renal context and relevant medicines; laboratory reference interval and any critical-result flag. Note missing information explicitly.

3. Develop the pharmacy assessment

Check the units, timing and specimen flags. Identify a result needing prompt clinical escalation under local policy and discuss potential confounding; do not independently prescribe a correction from this record.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Report / date / specimen	_____
Result / unit / local interval	_____
Previous result and trend	_____
Medicine-related review issue	_____
Escalation / supervisor decision	_____
Follow-up result	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. Why collect patient-specific information?

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

Medication-history Interview 1 - Admission

Experiment 13 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Teaching scenario: A patient is admitted with an incomplete medicine list.

Aim

To obtain and reconcile an accurate medicine history.

Principle

Medicine reconciliation compares a verified history with current orders and makes intentional changes explicit.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm pre-admission prescribed and non-prescribed products; allergy reaction details and last administration; permission to access records and confidentiality. Note missing information explicitly.

3. Develop the pharmacy assessment

Use a structured interview plus an available independent source such as packaging, a prior list or authorised pharmacy record. Record name, formulation, schedule, actual use and uncertainty. Compare the verified history with admission orders and refer discrepancies.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Case and information sources	_____
Medicine / formulation / actual schedule	_____
Allergies and reactions	_____
Last use / indication	_____
Discrepancy and clarification	_____
Verified list / handover	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. Why collect patient-specific information?

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

Medication-history Interview 2 - Polypharmacy

Experiment 14 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Teaching scenario: A patient uses medicines from several prescribers.

Aim

To obtain and reconcile an accurate medicine history.

Principle

Medicine reconciliation compares a verified history with current orders and makes intentional changes explicit.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm all prescribers/products and actual use; duplicates, self-medication, adverse effects and adherence; permission to access records and confidentiality. Note missing information explicitly.

3. Develop the pharmacy assessment

Create one reconciled medicine list and map each product to an indication. Identify duplicates, conflicting instructions and practical barriers for review; never silently stop a medicine during the history interview.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Case and information sources	_____
Medicine / formulation / actual schedule	_____
Allergies and reactions	_____
Last use / indication	_____
Discrepancy and clarification	_____
Verified list / handover	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. Why collect patient-specific information?

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

Medication-history Interview 3 - Transfer of Care

Experiment 15 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Teaching scenario: A patient moves between care settings.

Aim

To obtain and reconcile an accurate medicine history.

Principle

Medicine reconciliation compares a verified history with current orders and makes intentional changes explicit.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm last verified list and current orders; intentional changes and receiving-team needs; permission to access records and confidentiality. Note missing information explicitly.

3. Develop the pharmacy assessment

Compare the sending and receiving lists, verify each intentional change and highlight unresolved discrepancies. Communicate an accurate list with the next action owner and document the handover.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Case and information sources	_____
Medicine / formulation / actual schedule	_____
Allergies and reactions	_____
Last use / indication	_____
Discrepancy and clarification	_____
Verified list / handover	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. Why collect patient-specific information?

Medicine decisions depend on the individual indication, risks, current treatment and monitoring needs.

2. What makes a pharmacy intervention useful?

A specific identified problem, a justified action, a clear communication route and a documented outcome.

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