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FACULTY OF PHARMACY + PHARMACEUTICAL SCIENCES

Guide to Pharmacist Documentation of Patient Care

A Companion Guide to the Patient Care Process



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Preface

The purpose of this guide is to serve as a companion document to the *Pharmacist Patient Care Process* and to describe the important aspects of documentation to ensure a complete and accurate patient record is maintained. Effective documentation captures the patients' reason for seeking care, health needs and goals in addition to the clinical reasoning, interventions, monitoring plans, and outcomes associated with pharmacist-provided care. This enables seamless communication among healthcare providers and continuity of care, and supports optimal decision-making. It also serves as a legal record of care, a tool for quality improvement, and evidence of the pharmacist's role in patient outcomes.

This guiding document provides pharmacy students and pharmacists with a framework for consistent, comprehensive, and professional documentation practices across a variety of care settings. It outlines key principles, standards, and examples to support pharmacists in recording their contributions to medication management and patient care. It should serve as a starting point for developing and improving your documentation. The ultimate goal is to enhance patient safety, support interprofessional collaboration, and demonstrate the value of pharmacy services within the broader healthcare system.

The Standards of Practice for Pharmacists and Pharmacy Technicians by the Alberta College of Pharmacy outlines the standards for documenting in the patient record.

Documentation Guide Working Group Members

Rene Breault (Lead)
Academic Lead, Practice Innovation
Clinical Professor, Faculty of Pharmacy and Pharmaceutical Sciences

Damion Barnes
Assistant Clinical Professor, Faculty of Pharmacy and Pharmaceutical Sciences

Dylan Moulton
Assistant Clinical Professor, Faculty of Pharmacy and Pharmaceutical Sciences

Essi Salokangas
Assistant Clinical Professor, Faculty of Pharmacy and Pharmaceutical Sciences

Acknowledgements

PharmD Advisory Council Members
Christopher Wright (Community Pharmacist), Jak Novovic (Acute Care Pharmacist)

Alberta College Of Pharmacy
Melanie Danilak, Monty Stanowich, Sheila Walter, Vince Seo

Characteristics of An Effective Documentation Note: Guiding Principles

Clear	Concise	Organized	Professional	Accurate & Accessible
• Another reader should be able to understand the message • Legible, make sure if it is handwritten that another can read it easily. • All necessary information is included • Use consistent language and terminology • Use appropriate abbreviations	• Include only relevant details • Minimize duplication of information	• Have clear headings • Have a logical flow • Prioritize what is important	• Use language that is non-stigmatizing • Avoid blame or criticizing	• Ensure what is written matches with what happened • Write during the encounter or promptly after • Documentation should be retrievable and shareable to facilitate continuity of care

Adapted From: Alberta College of Pharmacy, Continuing Competence Module “Documentation”. Accessed July 4, 2025.

Factors to Consider When Documenting Care

Documentation allows for a written history as well as insight into a patient's health journey. The words we choose can shape how future providers will perceive a patient's identity, behaviour, condition, and credibility. The language we use impacts how another reader may view a patient. Although the information you write may be objective to you, another reader can interpret the document in a way that could cast doubt, portray the patient negatively, or imply patient responsibility. The words we use can work to perpetuate stigma and bias.

Pharmacists should prioritize documenting in a manner that is person-centered, respectful, and strengths-based. Where possible, language should humanize and empower patients. Documentation should reflect patient perspectives and their agency focusing on their strengths, goals, and efforts. Avoid referring to specific patient descriptors (sex, gender, race, etc) unless medically relevant. Document observable facts rather than assumptions, and frame patient behaviours within their social and structural contexts (living situation, community, economic status, or other social determinants of health). Where possible, pharmacists should identify system or provider-level barriers that can be mitigated. Your documentation should help future providers build understanding for continuity of care, not reinforce stereotypes.

Reason for documentation

When starting the document consider why the document is required and what it is for

- **Example situations where documentation is required:**
    - Care plan summary for other healthcare provider/patient
    - Documentation of a patient interaction
        - Requires follow up
        - Record of counselling/patient education
    - Drug therapy problem assessment and recommendation
    - Best Possible Medication History
    - Medication Reconciliation

Audience/Practice setting

Consider the audience and setting of who will be reading the note in the future

- Pharmacy profile note will likely be read by other pharmacists
- Hospital chart note will be read by a multitude of professions
- Faxed note/letter to other healthcare provider will be unique to the other provider

Clarity, Tone and Language

It is important for a note to be understood to ensure effective communication

- Technical standards
    - The note should be clear, concise, logical, objective, professional
    - Avoid rewriting, deleting, or removing any part of the record
        - If handwritten any error should be crossed out with a single line and initialled
    - Ensure legibility, especially if handwritten
    - Clearly indicate if the documentation extends to another page

- Communication
    - Diplomatic, appropriate tone
    - **Appropriate terms**: *may benefit from, may improve with, may no longer require, suggest, recommend, consider, patient would prefer, patient may face barriers to adherence due to "X", patient stated, patient reports, patient indicates*
    - **Avoid these terms**: *wrong, unnecessary, must, should, inappropriate/ not appropriate, patient does not want, patient claims*
    - Avoid being judgemental, criticizing or blaming others for errors in documentation
    - Focus on solutions, not problems
    - Ensure quotations are used in a purposeful and intentional manner (e.g.: when a patient describes a qualifier for a symptom)
    - Include significant and relevant information only
- Drug Names
    - Generic names are preferred whenever possible; consider the setting, intent, and recipient of the documentation
    - Do not capitalize (including generic drug names) in the middle of a sentence
    - Use of brand names only for longer combination products (e.g. triamterene/hydrochlorothiazide- Dyazide®) or to clarify a specific product/dosage form (i.e. Cardizem CD® vs. Tiazac®)
    - If a brand name is used, follow it by ®
- Abbreviations
    - Use common or approved abbreviations only
    - Spell out drug names, directions (i.e. spell out IU, U, QD, qd)
    - Zeros: do not include a zero after a decimal point; always put a zero before a decimal point

    - Avoid other dangerous abbreviations. Review ISMP's Dangerous Abbreviations, symbols and dose designations for more information about unsafe documentation

Timelines

- Document in a timely manner (during or promptly after the encounter) to ensure expedient communication of care provided to patients
- If documentation has to be entered a day or more after, this should be clearly stated at the beginning of the note
- Delays in documenting may lead to missing/inaccurate information

Method of Documentation

- Consider how another person will read and access the note
- Handwritten versus typed notes may be appropriate depending on what you are documenting
    - Consider if the note will be relevant in the future where ease of access in an EMR will be appropriate
    - It may be relevant to handwrite if it is a simple change and can be documented with the prescription
- Consider if this note will be relevant to longitudinal care and will need to be accessed routinely
- Consider cross-referencing documents especially if using multiple pharmacy systems

Documentation Styles

The style of documentation that you choose to use will depend on the factors in the previous setting

- **Unstructured and semi-structured notes**
    - May be appropriate for a clarification, routine follow-up, patient care activities (i.e., patient education), or a straight-forward intervention (i.e. IV to PO conversion, use of a non-formulary drug)
- **Pre-printed forms or templates** (i.e. medication reconciliation, consultation note, clinic visit sheet, history intake form, digital template tools)
- **Structured documentation**
    - DAP (data, assessment, plan)
    - SOAP (subjective, objective, assessment, plan)
    - FARM (findings, assessment, recommendations, monitoring)
    - DDAP (drug-therapy problem, data, assessment, plan)

Documentation Tips

- **Not all components of a detailed care plan are necessary to document in the patient's medical record**. Depending on the type of issues identified, the practice site and the recipient(s) of the note, components of documentation may vary
- Avoid irrelevant repetition of information already documented in the patient record. Ensure to include only the relevant and necessary information required to support your recommendations
    - Having clear sections in a structured note will reduce repetition
- Prioritization and organization is especially important if multiple problems are being addressed
    - Prioritize and list primary issues first
- Conciseness is preferred in most pharmacist care practices
    - This can vary depending on individual practice but it is usually best to avoid long narratives
    - Avoid long narratives
    - Document essential information only
    - Ensure that other providers can access the necessary information
- The use of templated documentation tools may add irrelevant or non-patient specific information - it is important to avoid this whenever possible
- **Ensure patient identifiers, time/date of encounter, and pharmacist information is included**
    - Many Electronic Health Records (EHR) will do this automatically
- Documents shared externally may require a pharmacists signature
- If using technology such as Artificial Intelligence (AI) to transcribe or assist with documentation, it is the pharmacist's responsibility to ensure the final note is accurate and reflects the care provided

Documenting Using DAP (Data, Assessment, Plan)

DAP is one format for documenting care provided to patients. The following provides an outline of the components that should be included in each of the sections of the documentation.

Other types of documentation may be formatted differently. See Appendices for examples of different styles of documentation.

DATA

- Relevant subjective and objective data about the patient using a structured format (i.e. medical conditions, medications, relevant laboratory results…) for presenting data
- Includes only pertinent information based on the type of patient assessment being completed
- Includes relevant negative information. Include information that you assessed for signs and symptoms and that they are not present

ASSESSMENT

- Assessment of the data (what is your professional interpretation of the data presented above?)
- Were there any drug therapy problems or issues identified? If so, they should be listed here with supporting rationale (e.g. evidence-based resources, clinical guidelines, hospital formulary, the Alberta Blue Cross Drug Benefit List, Netcare reference ranges, etc.)
- Assessment of relevant therapeutic goals/targets/desired outcomes and patient goals and preferences
- Are medical conditions optimally managed? Does the patient require any additional information or education?
- Avoid introducing new data here

PLAN

- Suggest numbering items in the plan in appropriate order (e.g. based on priority, temporal sequence, or by disease state groupings)
- Therapeutic interventions or recommendations (drug and non-drug)
- Include drug regimen/product, dose, dosage form, route, frequency, duration
- Necessary education or referrals
- Monitoring plan and follow-up (tailor to practice site) including:
    - **WHO** will be responsible for monitoring
    - **WHAT** specific target/goal will be monitored, including threshold of concern
    - **WHEN** will follow up occur in terms of time frame and frequency

Appendices: Example Documentation Notes

These appendices provide a collection of pharmacist documentation examples from a variety of practice settings. It's important to understand these are offered as examples, not definitive "exemplars" or the sole correct way to document patient care. Documentation practices can vary significantly between different healthcare professions, across diverse practice environments, and even among individual pharmacists. A seemingly brief or incomplete note in these appendices may, in its original context, have been perfectly adequate, as other pertinent patient information was likely readily and routinely accessible elsewhere within that specific practice setting's record-keeping system. These examples are intended to illustrate the range and styles of documentation you might encounter, encouraging you to adapt best practices to your unique professional context rather than strictly replicate what is presented here.

As you review these examples and the broader guidance on pharmacist documentation within this document, we encourage you to critically reflect on your own documentation practices. Consider how you might have approached documenting the patient encounters presented. Are there elements you would have added or omitted, or perhaps phrased differently, based on your professional judgment and practice setting? This reflective exercise can help you internalize best practices and refine your approach to creating clear, comprehensive, and effective patient care documentation.

Appendix A: Community Pharmacy Documentation Notes

Example 1: Community Pharmacy Documentation Note

Acknowledgement: Dylan Moulton
Jan 16, 2025, 2:30 pm: Ineffective Pain Control
Patient: Jordan Smith **DOB:** Jan 1, 1963

D:

- Jordan presented to obtain a refill for ibuprofen for right ankle sprain (refer to initial note Jan 8, 2025) as they are going on a vacation and will run out before they return.
- Patient states that they are taking ibuprofen 600 mg PO with breakfast only, rather than the prescribed 600 mg TID, as they find the medication is "too strong" for them and is worried about experiencing side effects.
- Still experiencing pain (~6/10 from 7/10 prior to starting ibuprofen) with this dosing
- No red flags present (i.e., worsening of pain).
- Has followed RICE protocols initially recommended at last visit and finds pain is worse after a long day of work and better at night time when they put ice on ankle/elevated foot. Pain does improve once the ibuprofen takes effect in the mid-morning.
- Patient denies any issues tolerating medication.They have paused routine leisure/exercise activities like cross country skiing and walking until their sprain improves.
- No other Rx/OTC/NHP therapies, no other medical conditions, NKDA.

A: Jordan is experiencing ineffective pain management due to taking ibuprofen once daily in the morning rather than the prescribed TID regimen

Goals of therapy:

- Obtain adequate analgesia for ankle injury as soon as possible with a therapeutic option that the patient can adhere to (1-3 days/prior to trip)
- Return to regular functioning and cross country skiing/exercise routine once injury is healed (~7-14 days)

P:

1) **Recommend Jordan try an alternative medication regimen, naproxen 220 mg PO BID x 7 days.**
2) **Counsel/educate** Jordan on both similarities and differences of naproxen and ibuprofen
3) **Counsel/educate** about time to benefit (30-60 minutes), potential adverse effects and frequency (namely GI upset, 14% as per LexiDrug)
4) **Counsel/educate** about preferred administration: ideally with food to help mitigate GI related adverse effects, space doses apart by about 10-12 hours
5) **Counsel/encourage** the importance of ongoing non-pharmacologic measures (e.g., RICE method)
6) Jordan is to **self-monitor** for **both efficacy and safety:**

- Pain control: ideally 30-50% pain reduction from baseline (about 3/10 after analgesia). In about 7 days, he should reassess if pain is present. If it is, they are to call the pharmacist for reconsultation
- If pain has subsided and injury is healed, Jordan advised can return to regular exercise as before
- Adverse effects: if Jordan is experiencing any intolerable adverse effects, such as GI upset, they should contact the RPh
    - If at any point during therapy Jordan notes blood in stool (black tarry, or bright red), hematemesis or severe abdominal pain, should seek emergency services immediately

7) **Pharmacist** to **call** Jordan in **7 days** to assess pain control, safety parameters, and if adherence is improved.
8) Pharmacist to inform Jordan's family physician of change in therapy, and include rationale as to why.

Pharmacist Name/Contact information

Example 2: Longer detailed version - OTC Consult

Date/Time

Data

- Patient, 53 years old, with nasal congestion, sinus pain & rhinitis x 2 d; not seen doctor nor self-treated
- No complaints of fever, yellow/green nasal discharge, extreme facial pain
- No allergies to medications
- PMHx: Hypertension (well controlled on ramipril 5 mg daily and amlodipine 5 mg daily)
- BP today 117/81
- He is looking for a recommendation to help relieve his symptoms.
- Patient prefers a tablet but is open to using a nasal spray.

Assessment

- Pt exhibiting signs and symptoms of a viral URTI, which may resolve with OTC product.
- Therapeutic options include oral decongestant with an analgesic, topical decongestant nasal spray with an oral analgesic, or a nasal saline rinse with an oral analgesic.
- BP well controlled, but oral decongestant may increase his BP

Plan

- Long-acting oxymetazoline HCl 0.05% (Dristan®) nasal spray 1 spray into each nostril twice daily
- Acetaminophen 500 mg 1 tab every 6 hours x 2 days, then as needed for sinus pain.
- Proper nasal spray instructions given
- Patient was advised to use the nasal spray for only 3-5 days to avoid rebound congestion.
- Non drug measures provided (frequent hand washing, rest, avoidance of environmental tobacco smoke, use of a humidifier for steam inhalation, and saline nasal irrigation)

- Patient is also instructed if there is an abrupt worsening or no improvement in symptoms in 10-14 days, purulent nasal discharge, and facial pain with or without fever to return for further assessment to pharmacy, PCP, or urgent care as necessary
- Pt will call if any questions.

Pharmacist Name/contact information

Example 3: Brief, eDAP Version - OTC Consult

Date/Time

D: 53 y.o., nasal congestion, sinus pain & rhinitis x 2 d; no MD visit; no fever, yellow/green nasal discharge, extreme facial pain, NKDA, PMHx: controlled hypertension. Pt. prefers tablet but open to nasal spray dosage form

A: Likely viral URTI, oral decongestant may increase BP

P: Oxymetazoline HCl 0.05% (Dristan® LA) nasal spray 1 spray each nostril BID x 3-5 d maximum, acetaminophen 500 mg q6h x 2d, then prn pain. Patient education provided including non-drug measures. If abrupt worsening or no improvement in 10-14 d, see MD.

Pharmacist Name/Contact Information

Example 4: Community Pharmacy Documentation Note

Acknowledgement: Damion Barnes
Valtrex Prescribing for Shingles **Date:** May 18, 2025, 7:30 pm

Data:
Linda presents to the pharmacy with a 1-day history of tingling sensation that progressed to red, sore, itchy rash (burning pain 5/10) along with blisters under R/breast extending around to her back, following a single dermatome. Symptoms aggravated by tight clothing. No prior treatment attempted. Hx of chickenpox in teenage years; no prior herpes zoster. No: fever, N/V, broken skin, severe pain, bleeding or weeping. Labs (Jan 2025): eGFR 85 ml/min/1.73m², SCr 56 µmol/L, Clcr of 83 ml/min. Linda expressed wanting to get treatment quickly and is unable to access medical care (30km away, and it's currently a long weekend with walk-in clinics closed).

Assessment:
Linda presents with clinical signs and symptoms consistent with acute herpes zoster. She is a candidate for prescribing due to the limited access to medical care, the benefit of early treatment, and no red flags presented. Linda presents within the 72 hours treatment window for optimal benefit from therapy. Based on CPS - Herpesvirus infections, both valacyclovir and acetaminophen are indicated for her presentation, effective for their respective purposes (antiviral

and pain management), safe considering patient-specific factors (CrCl 83 mL/min, age, hypertension), and Linda expresses a willingness to adhere to both therapies. The goals are to reduce viral shedding, minimize pain, prevent new lesions, avoid complications, and ensure complete healing of lesions.

Plan:
Prescribed valacyclovir 1000 mg PO TID x 7 days and recommended acetaminophen 325-650 mg PO Q4-6H PRN; max 4000 mg/d with patient's consent. Provided education to keep rash clean and dry, cover the rash/blisters to prevent transmission, avoid scratching and wear loose-fitting clothing and to consider Shingrix vaccine in a year's time. Advised Linda to monitor daily for pain, rash, itching and tingling reduction with healing in 2-4 weeks. For her to monitor for headache, nausea or GI discomfort with valacyclovir use and to reach out to the pharmacist on duty if symptoms are bothersome or concerning.

RPh to follow up by phone in 3 days to assess tolerance, additional follow up in 3 weeks to assess for rash resolution. Linda advised to contact Dr. Jacob Fitz (family doc) if symptoms worsen, if symptoms spread or if pain persists after the rash has healed. Linda also advised to see an ophthalmologist urgently if ocular involvement occurs.

Pharmacist Name/Contact Information

Appendix B: Inpatient Pharmacy Documentation Note Samples

(Acknowledgement: Adapted from examples provided by the Clinical Practice Leaders, Pharmacy Services, AHS)

Example #1 Allergy Assessment
Date/Time
Pharmacist Note re: Codeine allergy assessment
Data: Patient noted to be allergic to codeine. Spoke with patient regarding allergy. Patient reports having being nauseated when given Tylenol #3 following dental procedure. Patient denies rash, difficulty breathing, or other symptoms. Explained nausea is likely an adverse effect to codeine rather than an allergy.

A/P: Patient's symptoms not consistent with drug allergy. Patient appears to understand information provided. Allergy status has been updated in the patient record.

Pharmacist Name/Contact information

Example #2A Allergy Assessment
Date/Time
Pharmacist Note re: Penicillin allergy assessment
Data: Patient noted to be allergic to penicillin and requires prophylaxis with cefazolin for pacemaker insertion. Spoke with husband as patient has Alzheimer's disease. Husband not aware of specifics of reaction but stated that it occurred during a previous hospitalization. Reviewed chart from October 2004 admission which reported a pruritic rash following two doses of IV cloxacillin for cellulitis and subsequently, patient was given IV cefazolin with no reported reaction.

A/P: Cefazolin appropriate prophylaxis for this patient as has previously tolerated same. RN aware.

Pharmacist Name/Contact Information

Example #2B Allergy Assessment (alternate format using bullet points)
Date/Time
Pharmacist Note re: Penicillin allergy assessment
Data:

- Patient has documented penicillin allergy
- Requires cefazolin for prophylaxis post-pacemaker insertion
- Nature of reaction: unknown, occurred during previous hospitalization
- Reviewed previous hospital chart, October 2004 which reported patient received cloxacillin, developed rash after 2 doses, subsequently received cefazolin with no problems

A/P:

- Cefazolin appropriate prophylaxis for patient (previously tolerated). RN aware.

Pharmacist Name/Contact Information

Example #3A TDM Consult- Gentamicin

Date/Time

Pharmacist Note re: Gentamicin therapy for urosepsis

Data: 87 y.o. female patient, 60 kg, admitted 1 week ago for treatment of CHF. Today, patient developed signs/symptoms of potential urosepsis with abrupt onset confusion and bacteruria, T38.1C. Foley catheter removed today. Urine culture pending (collected before first dose of gentamicin). Gentamicin 60 mg IV q8h has been ordered empirically. SCr stable at 138 µmol/L. Calculated estimate of CrCl ~ 25 mL/min.

A/P:

1. This patient is a suitable candidate for extended interval gentamicin dosing as per Bugs & Drugs guidelines
2. Recommend changing gentamicin dose to 420 mg IV q48h. (7 mg/kg x 60 kg)
3. Suggest 7-10 days of therapy (or 3 doses at q48h interval) depending on patient response (ie: resolution of confusion and bacteriuria).
4. Based on patient's age and changing renal function, recommend drawing an 8 hour gentamicin interval level following 2nd dose to confirm this dosage.
5. Once urine culture received, will check antibiotic susceptibility, discuss with team, and re-evaluate antibiotic choice.

Pharmacist Name/Contact Information

Example #3B TDM Consult- Gentamicin

Date/Time

Pharmacist Note re: Follow-up of gentamicin therapy (420 mg IV q48h) for UTI

Data: 87 y.o. patient, currently on day 3 of gentamicin therapy for treatment of *E. coli* in urine, sensitive to gentamicin. Blood cultures negative. Patient remains afebrile and confusion is improved. An 8 hour interval gentamicin level drawn yesterday after 1800h dose was 9.5 mg/L (drawn at 0145h). SCr 133 µmol/L.

A/P:

1. Recommend continuing with the current therapy based on Hartford Nomogram. Treatment length expected to be a further 5-7 days.
2. Repeat SCr levels should be drawn q3days to assess changes in renal function. Based on these SCr levels will assess need for further gentamicin levels.

Pharmacist Name/Contact Information

Example #4 Antibiotic choice/ IV-PO therapy

Date/Time

Pharmacist Note re: Antimicrobial therapy for CAP

Data: 56 y.o., COPD patient admitted through ER with LLL pneumonia, levofloxacin 500 mg IV daily x 10 days ordered. Recent use of macrolide therapy supports the use of levofloxacin in this case. Current recommendation for levofloxacin dosing from IDSA CAP guidelines is 750 mg PO/IV daily x 5 days for moderate pneumonia in a hospitalized patient with a normal CrCl (Scr = 95 µmol/L, wt = 72 kg, CrCl ~80 mL/min). Bioavailability of levofloxacin is 100% making oral therapy as effective as IV. Patient is not suffering from nausea and able to tolerate oral medications.

A/P:

1. As per AHS auto-substitution policy, the IV levofloxacin order will be substituted with oral therapy. In addition to this substitution, recommend increasing the dose to 750 mg PO daily.
2. Recommend pneumococcal vaccination of patient prior to discharge.
3. Writer will follow up with patient in a.m. to ensure they are tolerating oral therapy.

Pharmacist Name/Contact Information

Example #5 Medication History

Date/Time

Pharmacist Note

Re: Medication history POD#1

75 y.o. female admitted for hip replacement surgery.

PMH: atrial fibrillation and COPD, non-smoker x 10 years

Patient self-reports taking:

- Warfarin 5 mg PO daily (ordered POD#1), INR 1.3 (therapeutic range 2-3)
- Metoprolol 50 mg PO BID (ordered), HR 60-70

Patient did not report any other medications. Netcare PIN profile shows prescriptions for ipratropium bromide 20 µg (Atrovent®) and budesonide 200 µg/formoterol 6 µg (Symbicort® 200 Turbuhaler) have been filled in the past 30 days. Contacted patient's home pharmacy (Drugs R' Us 456-8123) to confirm frequency.

- Atrovent® 2 puffs via inhalation QID (not ordered)
- Symbicort® 200mcg 1 puff via inhalation BID (not ordered)

Upon further discussion with patient, she confirmed she does take these medications at the above doses.

A/P:

1. Suggest ordering inhalers for use in hospital:
    - Ipratropium 20 µg 2 puffs via inhalation QID

    - Budesonide 200 µg/formoterol 6 µg 1 puff via inhalation BID
2. Writer will continue to follow INR for warfarin dosing
3. Patient appears to have good adherence with her medication regimen.
4. Education provided on importance of providing a complete medication history to ensure continuity of care.
5. Supplied patient with Medication Record card to keep in her purse for future admissions.

Pharmacist Name/Contact Information

Appendix C: Ambulatory Clinic Documentation Note Samples

Acknowledgement: Adapted from Christine Hughes and Mark Makowsky

Example #1: Assessment and management of anemia
Date/Time
Pharmacy Note Re: anemia

Data:

- Ms. Walter is a 32 y.o. female seen in clinic as part of routine follow-up for her pregnancy.
- Currently 32 weeks gestation. Patient complains of increasing fatigue and lethargy.
- On exam, patient appears pale and has notable nail bed pallor.
- RR 18, HR 98, BP 110/70
- Labs: Hgb 91 g/L, MCV 90 fL, MCHC 290 g/L, RDW 0.180, Iron 7 µmol/L, TIBC 80 µmol/L, Ferritin 11 µg/L, Folic acid 6.8 nmol/L, Vitamin B12 352 pmol/L.
- Peripheral smear demonstrates both microcytic and macrocytic erythrocytes and hypochromia.
- Patient ran out of Materna® multivitamin approximately 1 month ago; previous to this, patient had history of non-adherence due to financial barriers that have been resolved.
- Has not been able to eat much protein or vegetables during pregnancy due to morning sickness.

Assessment:

- Ms. Walters appears to have both iron deficiency anemia and macrocytic anemia (folic acid deficiency).
- This is mostly likely due to increased requirements during pregnancy and non-adherence with her multivitamin.
- Evidence of mixed anemia based on laboratory values and peripheral smear.

Plan:

- Started ferrous sulfate 325 mg three times daily and folic acid 1 mg/day to treat her anemia.
- Repeat CBC at next visit and in 2 months to ensure adherence and assess efficacy of therapy.
- Counselled patient on importance of folic acid/iron and recommend taking ferrous sulfate on empty stomach if possible.
- Writer will follow-up with patient by phone in 1 week to assess adherence and gastrointestinal upset/constipation.

Pharmacist Name/Contact Information

Example #2: Family Practice/Primary Care Note

Patient, DOB, PHN

Date/Time:_____

Reason for Referral: Asked to see patient by Dr. X in a family practice clinic for a complete medication review.

History of Present Illness (HPI)

DG is a 61 y.o. female (wt= 94 kg) who was recently admitted to hospital (date) for a zopiclone overdose and was discharged 2 weeks ago with several medication changes which were reviewed in this session.

Past Medical History (PMH)

1. Bipolar disorder: Depression predominant
2. Osteoarthritis: bilateral knee and hip (scheduled for knee replacement in ~3 months)
3. Hypertension since age 44
4. Type 2 DM x ~7 yrs
5. Hyperlipidemia
6. Obesity
7. Hypothyroidism
8. Rosacea
9. Anemia- resolved
10. ? Diverticular disease,
11. ? GERD/erosive gastritis
12. Osteoporosis- at risk

Past surgical history

Surgery to both knees

Social history (SH)

Never smoked, occasional alcohol use
Denies recreational substance use
1 sisters, 2 sons, 1 daughter
Lives in a seniors complex
Widowed

Family History (FH)

Mother: hypertension, CV disease, Diabetes
Dad: died of colon cancer

Allergies: NKDA

Current Medications

Obtained medication record from Rexall (ph: __) where meds are blister packed for the past 2 yrs. Patient states she takes all meds as prescribed from blister packs.

Tylenol #3® 1 tablet PO TID
Acetaminophen 500 mg PO TID
Senokot® 2 tablets PO at bedtime
Docusate sodium 100mg PO BID
Carbamazepine CR 400 mg PO daily
Olanzapine 10 mg PO qHS
Venlafaxine XR 225 mg PO daily (x 2wks)
Zopiclone 15 mg PO qHS (x 2 wks)
Minocycline 100 mg PO daily
Levothyroxine 0.025 mg PO daily
Glyburide 10 mg PO with breakfast, 5 mg with supper
Metformin 500 mg PO BID
Atorvastatin 20 mg PO HS (x 2 wks)
ASA 81 mg PO daily
Captopril 50 mg PO TID
Hydrochlorothiazide 25mg PO daily
Amlodipine 10 mg PO daily
Calcium Carbonate 500 mg PO TID
Vitamin D 400 IU PO BID

OTC/Herbal Meds

Gaviscon® 1-2tablets PO prn heartburn
Acetaminophen 325 mg 1-2 tablets PO as required for knee pain (using up to 6 additional tablets per day on top of regularly scheduled acetaminophen i.e., 4500 mg/day)
Denies herbal meds

ROS/Physical Exam

CNS: no further thoughts of suicide, states new antidepressants seems to be working; patient receiving psychological and social supports via primary care network
CVS: BP today 170/100 mmHg, pulse 94
MSK: some knee pain currently (3/10). Although pain has been much better controlled with regularly scheduled analgesic therapy, she still has pain limiting walking distance to 1-2 blocks.
GI: normal BM

Pertinent Labs

Last HbA1C (date): 6.3
Lipid Panel (date): TC: 5.42, TG: 1.56, HDL: 1.72, LDL: 3.24, TC/HDL: 3.4 (1 week prior to statin therapy)- high CV risk given diabetes Hx
TSH (date): 3.02
CBC, Lytes, SCr (date): WNL
Does FBG at home: reports readings of 7 this AM and 6.2 prior to lunch today.

Assessment/Plan:

This patient is navigating multiple chronic conditions and a complex mediation regimen. Recommendations to optimize and simplify their medication regimen are outlined below:

1. **Inadequately controlled blood pressure:** May be exacerbated by venlafaxine for treatment of depression, but this is required given good response for depression.
    - Recommend to discontinue captopril and start ramipril 10 mg PO daily to simplify regimen. Prescription provided. Recheck BP in 1 month in clinic. Goal for BP<130/80.
2. **Increased risk of mania with venlafaxine:** No change in therapy at present time. Monitor mood at next visit.
3. **Pain Control:** Recommend to increase Tylenol #3 1 tablet PO QID and acetaminophen 500 mg PO QID. Patient advised maximum dose of acetaminophen is 4g daily. Check pain control at next visit.
4. **Insomnia:** May improve as pain control improves with increased analgesia. Discussed non pharmacologic (sleep hygiene) measures. Consider zopiclone taper at next visit.
5. **Rosacea management:** Recommend to discontinue minocycline therapy. Reassess for recurrence at next visit.
6. **Medication regimen simplification:** Recommend to increase calcium carbonate to 1250mg PO BID (1000 mg elemental daily) and change Vit D 1000 U PO daily.
7. **Diabetes management**: Will review BG diary at next visit. Check lipid panel in 1 month given new statin therapy. Goal for LDL < 2 since (high risk CV category)
8. **Bowel regimen:** Continue current bowel regimen for now given increase in codeine dose. Will assess bowel status at next visit.

Thank you for the opportunity to support this patient.

Pharmacist Name/Contact information

References

Patient Care Process Document Version 3.0, Faculty of Pharmacy and Pharmaceutical Sciences, June 2025

Alberta College of Pharmacy. Standards of Practice for Pharmacists and Pharmacy Technicians. Accessed July 4, 2025

Model Standards of Practice for Pharmacists and Pharmacy Technicians in Canada. National Association of Pharmacy Regulatory Authorities. Accessed July 10, 2025