## Supplemental Information

1. **Your name**

2. **Patient's last name**

3. **MRN**

4. **Date and time of review (eg, 8/1/17 13:00)**

5. **Was this medication review related to an admission or transfer? (circle 1)**
   - Admission
   - Transfer

6. **For admissions:**
   - Number of home medications
   - (PRN medications excluded except for inhalers, nitroglycerin, opiates, seizure rescue, benzodiazepines, and sedatives)

7. **For transfers:**
   - Total number of medications on transfer
   - (PRN medications excluded except for inhalers, nitroglycerin, opiates, seizure rescue, benzodiazepines, and sedatives)

8. **For transfers:**
   - Has this admission been >60 days? (circle 1)
   - Yes
   - No

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### Continue with form if patient has ≥1 home medication(s)

9. **Was this completed within 18 hours of arrival to ICP (circle 1)?**
   - Yes
   - No (please explain)

10. **Source of medication review** (circle 1)
    - Patient
    - Family and/or caretaker
    - Residential facility
    - Other (please explain below)

11. **Time it took to complete the medication review**

12. **Number of medications with errors**

**Please continue if errors identified**

<table>
<thead>
<tr>
<th>Name of medication 1 associated with error</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Omission</td>
</tr>
<tr>
<td>2. Route</td>
</tr>
<tr>
<td>3. Frequency</td>
</tr>
<tr>
<td>4. Formulation</td>
</tr>
<tr>
<td>5. Timing</td>
</tr>
<tr>
<td>6. Dosing</td>
</tr>
<tr>
<td>7. Other (please explain below)</td>
</tr>
</tbody>
</table>

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**SUPPLEMENTAL FIGURE 6**

Data collection tool. ICP, intermediate care program; MRN, medical record number; PRN, pro re nata.
SUPPLEMENTAL FIGURE 6
Continued.

| Name of medication 2 associated with error | 1. Omission  
2. Route  
3. Frequency  
4. Formulation  
5. Timing  
6. Dosing  
7. Other (please explain below) |
|---|---|
| Error type of medication 2  
[may circle >1] |  |

| Name of medication 3 associated with error | 1. Omission  
2. Route  
3. Frequency  
4. Formulation  
5. Timing  
6. Dosing  
7. Other (please explain below) |
|---|---|
| Error type of medication 3  
[may circle >1] |  |

| Name of medication 4 associated with error | 1. Omission  
2. Route  
3. Frequency  
4. Formulation  
5. Timing  
6. Dosing  
7. Other (please explain below) |
|---|---|
| Error type of medication 4  
[may circle >1] |  |

| Name of medication 5 associated with error | 1. Omission  
2. Route  
3. Frequency  
4. Formulation  
5. Timing  
6. Dosing  
7. Other (please explain below) |
|---|---|
| Error type of medication 5  
[may circle >1] |  |