DATAFORM 1
Prescription Screening Form

1. Study ID Number: ____ ____-____ ____ ____ ____ ____

2. Reviewer ID Number: ____ ____

3. Provider ID Number: ____ ____-____ ____ ____

4. Number of prescriptions from index visit_____

5. Date of prescription(s) ____ ____ /____ ____ / ____ ____

6.	**Prescription 1.___**	**Prescription 1.___**	**Prescription 1.___**
7. Name of drug	_____	_____	_____
8. Index Visit	1. No 2. Yes		
9. Category of drug *(from table on next page)*	_____ If other, specify _____ ___	_____ If other, specify _____ ___	_____ If other, specify _____ ___

0. ACE inhibitor
1. Analgesic (narcotic)
2. Analgesic (non-narcotic, non-NSAID)
   2.01 Acetaminophen
   2.02 Other
3. Antianemia
4. Antibiotic
   4.01 Cephalosporins
   4.02 Clindamycin
   4.03 Macrolides
   4.04 Misc. antibiotics
   4.05 Ophthalmic preps
   4.06 Otic Preps
   4.07 Penicillin or derivative
   4.08 Quinolones
   4.09 Sulfa
   4.10 Tetracycline
   4.11 Topical
   4.12 Other
   4.13 Nitrofuran antimicrobial
5. Anticoagulant
6. Anticonvulsant
7. Antidepressant
8. Antifungals (oral)
9. Antifungals (topical)
10. Antihelmintics
11. Antihistamine (all forms)
12. Antihypertensive
13. Antineoplastic
14. Antipsychotic
15. Antituberculosis
16. Antitussive
17. Antiviral (all forms)
18. Bronchodilator (inhaled)
19. Bronchodilator (oral)
20. Decongestant
21. Diabetes (oral agents)
22. GI Meds
   22.01 Antiflutlent
   22.02 H2 blocker
   22.03 Proton pump inhibitor
   22.04 Probiotic
   22.05 Antacid
   22.06 Laxative
   22.07 Other
23. Insulin
24. Leukotriene Receptor Antagonists
25. Local Anesthetic
26. Muscle relaxants
27. Nasal Sprays
28. NSAID
   28.01 Ibuprofen
   28.02 Other
29. Oral contraceptive
30. Sedative, hypnotic
31. Steroids (inhaled)
32. Steroids (oral)
33. Steroids (topical)
34. Stimulants
35. Thyroid agents
36. Vaccines
37. Vitamins
38. Other
39. Scabicide
40. Contraceptive (injectable)
41. Contraceptive (patch)
42. Dermatologicals
43. Emollients
44. Epinephrine
45. Immunologicals (topical)
46. Iron
50. Antianxiety
51. Beta blocker
52. Estrogen, topical
55. Hemostatic
56. Mast cell stabilizer
57. Antiarrhythnmics
58. Anticholinergic
59. Antiemetic
60. Kertolytic
61. Anti-Parkinson
62. Barbituate
63. Cholesterol medication
64. Digoxin
65. Diuretics
66. Electrolyte concentrates
67. Estrogen Replacement Therapy
68. Immunosuppressants
69. Nicotine
70. Cox 2 Inhibitors

	Prescription 1.___	**Prescription 1.___**	**Prescription 1___**
9. Route *(complete specify field for response 8 only)*	_____ Specify: _____	_____ Specify: _____	_____ Specify: _____
	1. PO 2. Topical 3. Subcutaneous 4. Rectal 5. Otic 6. Eye 7. Inhalation 8. Other, specify 9. Not specified 10. Nasally 11. As directed 12. Illegible		
10. Frequency *(complete specify field for response 7 or 8 only)*	_____ Specify: _____	_____ Specify: _____	_____ Specify: _____
	1. Once per day 2. Twice per day 3. Three times per day 4. Four times per day 5. Once per week 6. As needed 7. As needed, every ___ _____; specify 8. Other, specify 9. Not specified 10. As directed 11. Illegible		

	Prescription 1.___	**Prescription 1.___**	**Prescription 1.___**
11. Duration of therapy	_____	_____	_____
	1. Short course <1 month—28 days or less) 2. Long term (>1 months—28 days or more) 3. Not specified 4. PRN 5. Not applicable 6. Known long term; duration not indicated 7. Other, specify 8. As directed 9. Illegible		
12. How many med errors were present	_____	_____	_____
13. How many near misses were present	_____	_____	_____

Needs Chart Review: (Check box for "Yes")