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| 【薬剤師と連携する時に使用します】 | | | | | | | | | | | | | | | | | | | | | | | | 令和 | | | | | | | | | | | | |  | | | | 年 | | |  | | | 月 | | | |  | | | | | 日 | | |
| **薬剤師連絡票** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **〈送信者記入欄↓　※薬剤師に確認したいことを記入してください〉** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **送信者** | | |  | | | | | | | | | | | | | | | | | | | |  | | | | **受信者** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| **医療機関・事業所名** | | | | | | | | | |  | | | | | |  | | | |  | | | **薬局名** | | | | | | | | | | | | | | | | | | | | |  | | | |  | | |  | | | |
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| **担当者：** | | |  | | | | | | | | | | | | | | | | | | | | **担当者：** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| **TEL：** | | |  | | | | | | | | | | | | | | | | | | | | **TEL：** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| **FAX：** | | |  | | | | | | | | | | | | | | | | | | | | **FAX：** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| **メール：** | | |  | | | | | | | | | | | | | | | | | | | | **メール：** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| **【照会する目的及び薬剤師からの回答希望の有無】** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 目　　　的 | | | | | | 報告 | | | | | | | | | | | | | 連絡 | | | | | | | | | | | | | 相談 | | | | | | | | | | | | | | 返信 | | | | | | | | | | | | |
| 回答希望の有無 | | | | | | 回答は必要です | | | | | | | | | | | | | | | | | | | | | | | | | | 回答は不要です | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **【対象者情報】** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| （ﾌﾘｶﾞﾅ） | |  | | | | | | | | |  | | | | | | | | | | | | | 性別 | | | | | | | | 明治 | | | | | | |  | | | 年 | | |  | | | | | 月 | | | |  | | | 日 | |
| 名前 | |  | | | | | | | | |  | | | | | | | | | | | | | 男 | | | | | | | | 大正 | | | | | | |
| 女 | | | | | | | | 昭和  平成  令和 | | | | | | |
| 住　所 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 主治医 | | | |  | | | | | | | | | | | | | | | | | 医療機関名 | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| かかりつけ薬剤師の有無 | | | | | | | | 有 | | | | | | | | | | 無 | | | | | | | 薬剤師名 | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| 要介護状態 | | | | 自立 | | | | | | | | 事業対象者 | | | | | | | | | | | 要支援1 | | | | | | | | | | | | | 要支援2 | | | | | | | | | | | |  | | | | | | | | | | |
| 要介護1 | | | | | | | | 要介護2 | | | | | | | | | | | 要介護3 | | | | | | | | | | | | | 要介護4 | | | | | | | | | | | | 要介護5 | | | | | | | | | | |
| 嚥下状態 | | | | 「できる」 | | | | | | | | 見守り等 | | | | | | | | | | | できない | | | | | | | | | | | | | ※「飲み薬」のことで照会する場合のみ | | | | | | | | | | | | | | | | | | | | | | |
| **【主治医を除き、対象者に関わっている多職種】** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 氏名 | | | | | | | | | | | | | | 事業所名 | | | | | | | | | | | | | | | | | | | | | | | | 連絡先 | | | | | | | | | | | | | | | | | | | | |
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| **【連絡・照会内容】** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 対象者の現状 | | 薬の飲み忘れ・飲み間違いがある | | | | | | | | | | | | | | | | | | | | | | 服薬カレンダー希望 | | | | | | | | | | | | | | | | | | | 一包化希望 | | | | | | | | | | | | | | | |
| 薬の量・回数を自分で調整している | | | | | | | | | | | | | | | | | | | | | | | | | | 多剤併用のチェック（ポリファーマシー） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 薬についての理解が得られにくく、服薬拒否もある | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 服薬困難・嚥下困難がある | | | | | | | | | | | | | | | | | | | | | | | | | | 薬の粉砕希望 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 薬剤による副作用が疑われる所見がある | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 処方薬について、患者（介護者）の要望がある | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 麻薬処方箋の受け入れ可否 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| その他 | | | | | （ | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ） | | | |
| 栄養摂取法 | | | | | 経口 | | | | | | | | | | | 経管 | | | | | | | | | | （ | | | TPN | | | | | | | | | | | 胃瘻 | | | | | | | | | 経鼻 | | | | | | | | | ） |
| 《照会目的等》 | | | | | ※具体的に記入してください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | |
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| **〈薬剤師回答欄↓　※「回答が必要」とある場合は、送信者に回答してください〉** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 当連携シートで回答します | | | | | | | |  | | | | | | |  | |  | | | | |  | |  | | | | | | | | |  | | | | | |  | | | | | | |  | | | | | | |  | | | | | |
| 直接会って話をします | | | | | | | |  | | | | | | | 月 | |  | | | | | 日 | |  | | | | | | | | | 頃 | | | | | | に　　来局希望 | | | | | | | | | | | | | | | | | | | |
| 電話で話をします  　メールで回答します | | | | | | | |  | | | | | | | 月 | |  | | | | | 日 | |  | | | | | | | | | 頃 | | | | | | に電話を　ください　　します | | | | | | | | | | | | | | | | | | | |
| 〈連絡・照会に対するコメント〉 | | | | | | | | | | | | | 特に意見はありません。 | | | | | | | | | | | | | | | | | | | | | 下記のとおりです。 | | | | | | | | | | | | | | | | | | | | | | | | |
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※□はチェックボックスになっています。