#### NCAP Compliance Needs Assessment

##### Section 1 Patient details

|  |  |  |
| --- | --- | --- |
| Patient name: | DOB | Interview No. |

**Section 2- Medication details AND ability to manage medicines**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Comments** |
| 1.Who orders repeat prescriptions? |  |  |  |
| 2. Who collects repeat prescriptions? |  |  |  |
| 3. Does your medication ever run out? |  |  |  |
| 4.Can you tell me what your medication is for? |  |  |  |
| 5.Can you tell me when you take your medicine? |  |  |  |
| 6.Do you ever forget to take medicine? *(circle)* |  |  | Never frequently sometimes |
| 7. Do you ever choose not to take your medicine? *(circle)* |  |  | Never frequently sometimes |
| 8. Does anyone/thing help remind you to take medicine? |  |  |  |
| 9.Can you open child resistant tops? |  |  |  |
| 10.Can you open foil blisters? |  |  |  |
| 11. Can you read the labels/ patient information leaflets? |  |  |  |
| 12.Can you measure liquids? |  |  |  |
| 13.Can you use inhalers/eye drops? |  |  |  |
| 14.Can you swallow all of your medication |  |  |  |

|  |  |  |
| --- | --- | --- |
| Pharmacy name  Tel: | Assessor’s name  Signed  Date | Duration of assessment  Location of assessment  Source of referral |

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##### NCAP Notes

# Date of assessment

# Date of Review

# Date of Review

**NCAP Assessment of the need for an MCA**

# Medication (*complete 1-5)*

1. Number regular medication = \_\_\_\_\_
2. Number of times/day medication is to be taken = \_\_\_\_
3. Number of as required medication = \_\_\_\_\_\_
4. Is regimen stable (no dose titration) Yes No
5. Are all drugs suitable for inclusion in an MCA Yes No

The pharmacist and patient/carer have carried out a compliance assessment and after considering all the alternatives and inclusion criteria, have decided that an MCA is the most appropriate compliance aid.

If patient **does not** fall within the eligibility guidance please comment

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**Following a demonstration** of the aid please ask the following questions

**Y N**

Do you find it easier to take the tablets from this

system than the packets you have at present?

Do you understand how the system works and

where the next dose should come from?

Do you understand how to take medication

that is not included in the aid?

Type provided \_\_\_\_\_\_\_\_ to be filled by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The assessor will review patient in 1 week and in one month**

|  |  |
| --- | --- |
| Pharmacy name:  Address:  Tel: | Assessor’s Name:  Signed  Date: |

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