#### 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 nameTel: | Assessor’s nameSignedDate | Duration of assessmentLocation of assessmentSource 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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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:SignedDate: |

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