Pharmacy Appointment Check List

<u>In preparation for your appointment with the pharmacist, the following immunization record and medication list will be required for you to send to us one week from the date you receive this packet.</u>

<u>IMMUNIZATION RECORDS</u>: Please provide the following vaccine records or work on obtaining the vaccines. Your dialysis center, primary care provider, local health department, and/or any retail pharmacy will be able to help.

PATIENT NAME (Print) _____

Vaccine name	**Date of my vaccine**	**My appointment date for the vaccine (*fill out blank bellow if you did not have the record but have appointment to get vaccine in the future).***
Influenza (Only needed during September to March)	----------	_____
Hepatitis B series	My last HBsAB titer at dialysis_____(ask dialysis nurse to help you) Or fill out the date of your shots #1 shot: _____ #2 shot: _____ #3 shot: _____ #4 shot: _____	Shot #1_____ Shot #2_____ Shot #3_____
Tetanus, diphtheria, and whooping cough (Tdap)	_____(must be within the last 10 years)	_____
Prevnar 13 (conjugated pneumonia vaccine)	_____ (one shot for life). Ask your dialysis nurse for help.	_____
Pneumovax 23 (polysaccharide pneumonia vaccine)	_____ (must be within the last 5 years). Ask your dialysis nurse for help.	_____
Shringrix (Shingles) (only if you are 50 years old or above)	Shot #1_____ Shot #2_____	Shot #1_____ Shot #2_____

_____ _____

Patient Signature Date

PATIENT NAME (Print): _____

MEDICATION RECORD: Please provide a complete list of your current medications including over the counter, herbal supplements, natural products, insulin products, etc… Please include medications that you only takes on an as needed basis as well. (Please use separate sheet of paper if additional space is needed.)

Medication name	**Dose**	**Indications**
Metoprolol tartrate 25mg	*2 tabs (50mg) two times a day*	*high blood pressure*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

In addition to listing your medication(s) above and submitting this form, ***you are required to bring ALL of your actual medications in their original bottles to your appointment****. Failure to provide any of this information or bring your medications to this appointment may result in delaying your transplant evaluation. Thank you for your cooperation and we are looking forward to meeting with you!*

_____ _____

Patient Signature Date