**Drug Regimen Review**

**Resident Audit**

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| **Resident Name** | **Drug Regimen Review every 30 days****(Yes/No)** | **Drug Regimen Review for Short Stay, Change of Condition, Hospice, Respite, High Risk, etc.****(Yes/No)** | **Irregularities noted****(Yes/No)** | **Report sent to DON, Medical Director and Physician****(Yes/No)** | **Physician Response in resident record including rationale for declining recommendations****(Yes/No)** | **Comments** |
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**Evaluator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**