# Unnecessary Drug Review

Facility Name: _____ Facility ID: _____ Date: _____

Surveyor Name: _____

Resident Name: _____ Room #: _____ Resident ID: _____

| Drug and dosage | Adequate indication for use | Adequate monitoring | For appropriate duration | Appropriate dose (consider duplicative therapy) | Gradual dose reductions (unless clinically contra-indicated) | Medication dose reduced or discontinued in presence of adverse drug reactions or side effects |
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**1. Did the facility, for each medication ordered, provide appropriate monitoring, duration, dose, and indication for use?** ☐ **Yes** ☐ **No** **F329**

NOTE: If the above question is answered "No", determine whether the consulting pharmacist identified the problem and brought it to the attention of the attending physician and director of nurses. If not, cite **F428**.

**Notes:**