Your Health and Safety is Important

60 or older?

You can receive a complete review of all your medications from a licensed pharmacist, at no cost.

- Over-the-counter
- Prescribed medications
- Supplements
- Sprays
- Creams
- Eye Drops
- Patches

A **complete** review of your medications and supplements.

A **customized** report from a pharmacist that Includes informative tips and alerts of potential negative interactions.

We will **contact** you to inquire how the services provided to you were beneficial.

Limited funding available for basic dental work, hearing, vision or certain assistive devices.

Complete an Intake Today!

jcapistran@capcog.org

www.aaacap.org

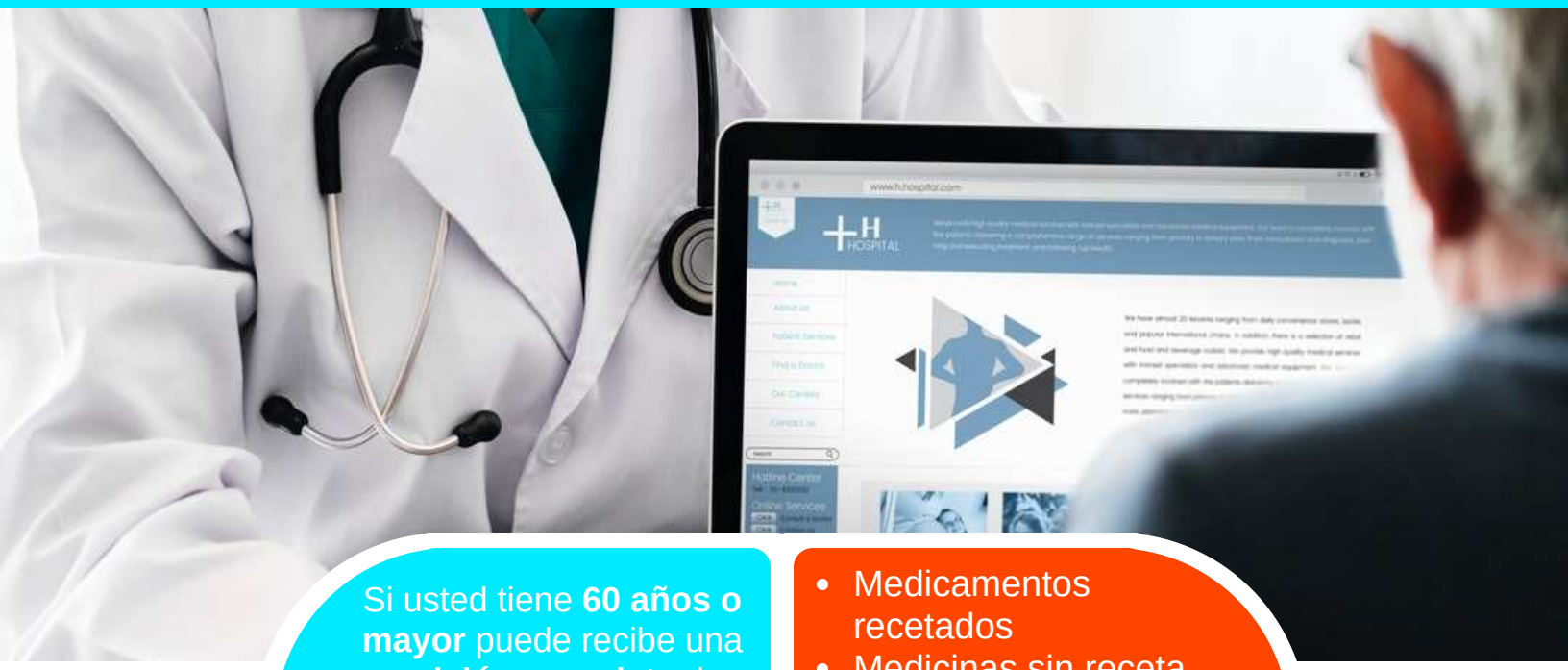
Toll-Free: 1-888-622-9111 x6059
Direct: 512-916-6059
Fax: 512-916-6042

6800 Burleson Rd.
Bldg. 310, Ste. 165
Austin, TX 78744

Area Agency on Aging of the Capital Area

This service is provided by AAACAP for Bastrop, Blanco, Burnet, Caldwell, Fayette, Hays, Lee, Llano, Travis and Williamson counties.
Funded in part by Texas Health and Human Services.

Su Salud y Seguridad es Importante



Si usted tiene **60 años o mayor** puede recibe una **revisión completa** de TODOS sus medicamentos por un **farmaceutico licenciado**, sin cobro!

- Medicamentos recetados
- Medicinas sin receta
- Vitaminas
- Suplementos
- Cremas
- Gotas para los ojos
- Parches

Una r**evision completa** de sus medicamentos y suplementos

Un informe **personalizado** de un farmaceutico, que incluye consejos informativos, alertas sobre posibles interacciones negativas

Nos pondremos en **contacto** con usted para asegurar que los servicios le beneficiaron

Fondos limitados disponible para asistir en servicios dentales basico, audicion, vision or ciertos dispostivos de ayuda

¡Llené un formulario, hoy!

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Area Agency on Aging of the Capital Area

Proporcionado por la Agencia para Adultos Mayores de la Área de la Capital para los condados Bastrop, Blanco, Burnet, Caldwell, Fayette, Hays, Lee, Llano, Travis y Williamson. Financiado en parte por el Departamento de Salud y Servicios Humanos.

Area Agency on Aging of the Capital Area

Medication Screening Intake

Today's Date: _____

Please print clearly and fill-out this intake, completely. Thank you!

Name: _____ DOB: _____ ☐ M ☐ F

Home Address: _____ City/St: _____ Zip: _____

Mailing Address: _____ City/St: _____ Zip: _____

Phone Number: _____ Alternate Number: _____

County: _____ Email: _____

At or below poverty level?

☐ **Yes** ☐ **No**

Persons in Family Unit	Poverty
1	$12,760 or below
2	$17,240 or below

Race:

- ☐ American Indian or Alaskan Native
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White Non-Hispanic
- ☐ White Hispanic
- ☐ Other Race
- ☐ Not Reported

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Not Reported

I authorize the pharmacist to speak to the following person/s (i.e. spouse, children, caregiver) in regards to my health conditions, medications and interactions: (optional)

☐ Name/Relationship: _____

☐ Name/Relationship: _____

Consumer Information Release

By signing this authorization, you are providing the Area Agency on Aging of the Capital Area (AAACAP) permission to release your information, which includes protected health information, to the Pharmacist. This will allow staff to assist in assessing, arranging and meeting your service needs, in particular to a medication screening. Failure to provide this authorization will result in limited service by the AAACAP. This release includes access to a continuum of service/s available through the AAACAP and/or its providers.

_____ _____

Consumer's Signature Date

Notice to Consumer:

- Once the authorization to release your information is granted, AAACAP is not responsible for any redisclosure of the information by the recipient.
- You can withdraw permission you have given the AAACAP to use, or disclose health information that identifies you; unless, the AAACAP has already taken action based on your permission. You must withdraw your permission in writing.

Consumer's Full Name:	**DOB:**

The following information is required for the Pharmacist to provide you with a complete customized medication screening.

Emergency Contact:_____ Phone: _____

Primary Care Physician:_____ Phone: _____

Smoke: ☐ No ☐ Yes; how much:_____

# of falls in the last 30 days: _____

Date of last flu vaccine: _____

Alcohol: ☐ No ☐ Yes; how much:_____

Year of last pneumococcal vaccine: _____

Caffeine: ☐ No ☐ Yes; how much: _____

Drug Allergies: _____

_____

Visual Impairment: ☐ No ☐ Yes:_____

Hearing Impairment: ☐ No ☐ Yes:_____

Dental Problems: ☐ No ☐ Yes:_____

Health Conditions: *(please list all known)* _____

_____

_____

_____

Please list any specific questions, concerns, comments or additional information you have for the pharmacist:

_____

_____

_____

_____

_____

_____

_____

Consumer's Full Name:	**DOB:**

Medication & Dosage (prescriptions, over-the-counter, herbals & vitamins)	**Qty**	**Date Last Filled**	**Directions** (as listed on pharmacy label)
Example: atorvastatin 20mg	30 days	1/3/2019	Take 1 tablet by mouth once daily

Your participation is greatly appreciated!

Revised: 1/2020