**SSRI checklist**

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| --- | --- |
| Patient NHI/Name | Date |

Process measures

1. If there are identified interactions with the SSRI and other prescribed medicines you have contacted the prescriber

Yes No NA (no interactions)

1. There is evidence you discussed the impact of interactions with other OTC medicines/supplements with the patient

Yes No

1. There is evidence you had a discussion about what the SSRI is for

Yes No

1. There is evidence the patient been informed about **when** and **how** to take the SSRI

Yes No

1. There is evidence you had a discussion about what to do if they miss a dose

Yes No

1. There is evidence you had a discussion about side effects

Yes No

*Questions 7-9 are patient questions to assess patient outcomes. Please refer to the measures and rationale table in the change package document regarding a follow-up phone call with the patient.*

Outcome measures

1. The patient could tell you **when** and **how** to take the SSRI

Yes No N/A

1. The patient could identify a side effect that they may experience

Yes No N/A

1. The patient could identify who to ask for help about their medicines or side effects

Yes No N/A