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| |  |  |  | | --- | --- | --- | | G:\Archivistes\Projet oWord\Gabarits\JMA\Logo\LogoCIUSSSCSIM.jpg | No de dossier : | RAMQ : | | Nom : | Prénom : | | DDN :       (     ) | Sexe : | | Début épisode : | No ch. : | | Md traitant : | |   \*SM02623\*  **FICHE DE COMMUNICATION GAP ET PHARMACIE COMMUNAUTAIRE** |

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| Site : |  | | | | | | | | |  | | | | | | | | | | | | | |
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| **Fiche de communication Guichet d’accès première ligne (GAP) et pharmacie communautaire**  (Usager non inscrit auprès d’un médecin de famille, usager avec RAMQ, usager du territoire (code postal ciblé) | | | | | | | | | | | | | | | | | | | | | | | |
| **PHARMACIE COMMUNAUTAIRE:** | | | | | | | | |  | | | | | | | | | | | | | | |
| Téléphone : | | |  | | | | | | | | | | | | | Télécopieur : | | | | | |  | |
| Pharmacien : | | |  | | | | | | | | | | | | | Licence : | | | | | |  | |
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| **Référence de la pharmacie vers le GAP** | | | | | | | | | | | | | | | | | | | | | | | |
| L’usager a donné son consentement pour le partage d’informations avec le GAP | | | | | | | | | | | | | | | | | | | | | | | |
| L’usager n’a pas réussi à obtenir un rendez-vous médical par lui-même | | | | | | | | | | | | | | | | | | | | | | | |
| **Raison(s) de consultation** | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | **Consultation médicale ponctuelle** | | | | | | | |
| Période maximale admissible de prolongation atteinte | | | | | | | | | | | | | | | | Condition mineure non éligible à la loi 31 (s.v.p. spécifier) | | | | | | | |
| Réévaluation médicale requise par un professionnel | | | | | | | | | | | | | | | |  | | | | | | | |
| Date et endroit de la dernière visite médicale (si connu): | | | | | | | | | | | | | | | | Autre : | | |  | | | | |
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| **Réévaluation médicale requise** | | | | | | | | | | | | | | | | | | | | | | | |
| Traitement n’est plus jugé optimal (ex. : ajout de molécule requis) | | | | | | | | | | | | | | | | | | | | | | | |
| Signaux d’alarme (signes, symptômes ou labos anormaux) : | | | | | | | | | | | | | | |  | | | | | | | | |
| Autres : | |  | | | | | | | | | | | | | | | | | | | | | |
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| **Autres informations pertinentes à partager:** | | | | | | | | | | | | | | | | | | | | | | | |
| Ajustement de la médication déjà réalisé par le pharmacien et pourra être poursuivi après l’évaluation médicale | | | | | | | | | | | | | | | | | | | | | | | |
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| Usager a été référé aux programmes de maladies chroniques? | | | | | | | | | | | | | | | | | | | | | | | |
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| **PRIORITÉ POUR RENDEZ-VOUS** | | | | | | | | | | | | | | | | | | | | | | | |
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| A1 ≤ 36 heures | | | | | | | A2 ≤ 72 heures | | | | | B ≤ 10 jours | | | | | | C ≤ 28 jours | | | | | D ≤ 3 mois |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| **Commentaires:** | | | |  | | | | | | | | | | | | | | | | | | | |
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| Nom et prénom du pharmacien | | | | | | | | | | |  | | Licence | | | | | | |  | Signature du pharmacien | | |
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| **RÉFÉRENCE DU GAP VERS LA PHARMACIE** | | | | | | | | | | | | |
| **Raison(s) de consultation** | | | | | | | | | | | | |
| Prolongation des ordonnances | | | | | | Vaccination : | | | | | | |
| Ajustement et suivi par le pharmacien | | | | | | Autre : | |  | | | | |
| Condition mineure : | | |  | | |  | |  | | | | |
|  | | | | | | | | | | | | |
| **DÉLAI ATTENDU POUR RECEVOIR LE SERVICE** | | | | | | | | | | | | |
| ≤ 8heures | | ≤ 36 heures | | | ≤ 72 heures | | ≤ 10 jours | | Autre : |  | | |
| Pharmacien doit contacter le patient dans **un délai de 4 heures ouvrables** | | | | | | | | | |  | | |
|  | | | | | | | | | | | | |
| **RÉPONSE DE LA PHARMACIE** (À envoyer au GAP dans les plus brefs délais) | | | | | | | | | | | | |
| Référence acceptée | | | | | | | | | | | | |
| Référence refusée, justification : | | | |  | | | | | | | |
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| **Commentaires :** |  | | | | | | | | | | |
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| Nom et prénom de l’intervenant | | | |  | N° permis/titre d’emploi | | |  | Signature de l’intervenant | |
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