

Medication review template – Gabapentin and pregabalin *

Patient name: _____ DOB: _____ Date: _____

Clinician name: _____ NHS No.: _____

1. Purpose of review				
“We’re reviewing how your medicine is working for you, including benefits, side effects, and whether it’s helping your day-to-day life. We can decide together whether to continue, adjust, or try something different.”				
2. Current medication				
Medication	Dose	Frequency	Start date	Prescribing reason
3. Functional goals of treatment				
Prompt: “When this medicine was started, what were we hoping it would help with? And how is that going now?”				
Patient goals:				
4. Medication effectiveness				
Prompt: “Let’s look more closely at how the medicine is helping day-to-day.”				
Medicine helping with?	Tick all that apply			
Pain relief (%)	<input type="checkbox"/> 0 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 40 <input type="checkbox"/> 50 <input type="checkbox"/> 60 <input type="checkbox"/> 70 <input type="checkbox"/> 80 <input type="checkbox"/> 90 <input type="checkbox"/> 100			
Helps during flare-ups	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially			
Mood or wellbeing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially			
Supports daily activity (e.g. moving, washing, dressing)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially			
Social activities (e.g. seeing people, going out)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially			
Work or usual daily roles	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially			
Helps you sleep better (so you function better in the day)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially			
Still meeting original functional goals	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially			

*An electronic template is currently being developed to allow access to this form via GP system EMIS.

5. Adverse effects or concerns		
Prompt: "Have you had any unwanted effects that might be linked to this medicine?"		
Adverse effects	Experienced? Tick all that apply	
Drowsiness/dizziness/fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Balance problems or falls	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cognitive effects (e.g. memory problems, feeling slowed down)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Weight gain or increased appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mood changes (e.g. low mood, irritability, anxiety)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blurred vision or visual disturbance	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Changes in bowel habit (e.g. constipation or diarrhoea)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Swelling of feet, ankles or hands	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Breathing difficulties (e.g. breath-holding or episodes where people feel they must initiate breathing)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other (patient reports):		
6. Dependence/withdrawal features		
Prompt: "Any symptoms if you miss a dose or try cutting down?"		
<input type="checkbox"/> Anxiety/restlessness <input type="checkbox"/> Tremor <input type="checkbox"/> Sweating <input type="checkbox"/> Muscle aches/'flu-like' <input type="checkbox"/> Rebound pain <input type="checkbox"/> Nausea <input type="checkbox"/> Other: _____		
7. Patient reflections: benefits vs downsides		
"Looking at everything, do you feel this medicine is still helping more than it's causing problems?"		
Benefits (+)	Problems (-)	
<input type="checkbox"/> More benefits <input type="checkbox"/> More problems <input type="checkbox"/> Mixed/unclear		
8. Non-pharmacological options		
"Sometimes combining medicine with other tools works even better. Let's look at what you've tried or might be open to."		
Option	Already using?	Offer/refer?
Pain education programmes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychological support e.g. CBT if available	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physiotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep/stress management	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mindfulness/pacing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Self-management resources e.g. Living Well with Pain, Pain Concern information, Pain Toolkit or EPP Cymru	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

9. Clinical safety and deprescribing		
Risk area	Present?	Action prompt if present
Renal impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Check CrCl → adjust dose; accordingly, consider dose reduction if adverse effects
Concomitant opioid use	<input type="checkbox"/> Yes <input type="checkbox"/> No	Increased risk of sedation and respiratory depression → consider dose reduction or taper of one or both
Other CNS depressants (e.g. benzodiazepines, Z-drugs)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Review need and reduce total sedative load where possible
Respiratory disease (e.g. COPD, sleep apnoea)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Increased risk of respiratory depression → use caution; consider dose reduction
High dose without clear benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reassess effectiveness → consider reducing dose
Frailty or falls risk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Increased risk of falls and harm → consider lower dose or alternative; review need
Cognitive impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Risk of confusion and harm → review need
Substance use/misuse risk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Consider safer alternatives/ mental health support
If ANY of the above are checked "Yes", consider <input type="checkbox"/> Gradual dose reduction <input type="checkbox"/> Reduce dose to lowest effective level <input type="checkbox"/> Switch to alternative treatment <input type="checkbox"/> Increase monitoring (e.g. review sooner) <input type="checkbox"/> Refer to: <input type="checkbox"/> Mental health <input type="checkbox"/> Pain team <input type="checkbox"/> Falls team <input type="checkbox"/> Respiratory		
10. Planning together – shared options		
Prompt: "Let's decide together what the best next step is. Sometimes medicines can cause more harm than good over time. Would you be open to making changes gradually?"		
Option	Tick	Notes
Continue current dose (only if meaningful benefit)	<input type="checkbox"/>	Maintain lowest effective dose
Adjust dose (increase or reduce as appropriate)	<input type="checkbox"/>	↑ only if some benefit; ↓ if adverse effects
Gradual dose reduction (if no meaningful benefit or harms outweigh benefits)	<input type="checkbox"/>	Use stepwise taper
Switch to alternative medicine	<input type="checkbox"/>	Consider if not tolerated
Focus on non-pharmacological support	<input type="checkbox"/>	Reinforce activity, pacing, support
Other plan:	<input type="checkbox"/>	
11. Follow-up and support		
Next review date:		
Resources shared today:	<input type="checkbox"/> Live Well with Pain <input type="checkbox"/> Pain Concern information <input type="checkbox"/> Pain Toolkit <input type="checkbox"/> EPP Cymru <input type="checkbox"/> Other _____	