MEDICATION PROFILE

PATIENT LAST NAME	FIRST NAME	MI	MEDICAL RECORD NUMBER
ALLERGIES		HEIGHT	WEIGHT
PHARMACY	PHONE	FAX	

START DATE	D/C DATE	MEDICATION	DOSE	ROUTE	FREQ	N	C	PURPOSE
						☐	☐	
						☐	☐	
						☐	☐	
						☐	☐	
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						☐	☐	
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						☐	☐	
						☐	☐	
						☐	☐	

O_2 at ___ l/min freq ______________________ via _________________________________ inhalation

Please list all wound cleansers + ointments / topical:

Medication Administered by:

Knowledge of Meds: ☐Good / ☐Fair / ☐Poor

Home Med. Record Provided: ☐ YES ☐ NO ☐ REFUSED

Comments:

Management of Oral Medications: Refers to the patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. **(Note: This refers to ability, not compliance or willingness.)**

☐ 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
☐ 1 - Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advanced by another person; or (b) another person develops a drug diary or chart.
☐ 2 - Unable to take medication unless administered by someone else.
☐ 3 – Unable to take medication unless administered by another person.

Clinician Name & Signature:

Date: