Universal Medication Form (Revision 01/23/06)

PATIENT	
Date of Birth	
Diagnoses	
Physician	**Telephone:**
Allergies	
Vaccinations	**Hepatitis:** **Tetanus:** **Pneumonia:** **Flu:**
Ability to manage medications	**Independent** **Type of assistance required:** **Assisted by whom:**

INCLUDE ALL MEDICATIONS TAKEN: EXAMPLE: PRESCRIPTIONS, NON-PRESCRIPTIONS, VITAMINS, HERBALS

For Hospice patients: Place an asterisk next to the medications that are covered by Hospice

For Home Care patients: Start of Care Resumption of Care Recertification PHARMACY:_____ Tele:_____

Date	Medications Generic/Brand Name	Dose	Route	Frequency Duration (dates)	Purpose	Prescriber	Nurse Initials

Patient Instructions: Keep this form with you at ALL times! Show it to every clinician involved in your care. Ask them to attach updates!
Clinician Instructions: This is not an official medical order form. Please attach any orders to this form.

Patient: _____

Universal Medication Form (continued)

Include ALL medications taken: example: prescriptions, non-prescriptions, vitamins, herbals

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