|  |  |
| --- | --- |
|  | Training Family Caregivers in Team-Based Medical Decisions  Medication List |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Record** | **As of:** |  | **Birth Date:** |  |
| Patient Name: |  | | | |
| Emergency Contact 1: |  | | Phone: |  |
| Emergency Contact 2: |  | | Phone: |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medications** | | | | | | |
| **Name of Drug** | 1 | 2 | 3 | 4 | 5 | 6 |
| Generic |  |  |  |  |  |  |
| Brand |  |  |  |  |  |  |
| OTC |  |  |  |  |  |  |
| **How medication is administered (pill, capsule, injection, patch, ointment)** |  |  |  |  |  |  |
| **Dosage** |  |  |  |  |  |  |
| **What medication looks like** |  |  |  |  |  |  |
| **What the drug is treating** |  |  |  |  |  |  |
| **Side effects I’ve experienced** |  |  |  |  |  |  |
| **How and when to take medication** |  |  |  |  |  |  |
| **What not to do when taking medication** |  |  |  |  |  |  |
| **Name of prescriber** |  |  |  |  |  |  |
| **Name of pharmacy that filled prescription** |  |  |  |  |  |  |
| **Date Started** |  |  |  |  |  |  |
| **Date Stopped** |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Immunizations** | |
| *Type* | *Date of Last Dose* |
| Tetanus |  |
| Pneumonia |  |
| Flu |  |
| Hepatitis |  |
| Other |  |

|  |  |  |
| --- | --- | --- |
| **Reactions** | | |
| *Drug allergies and other significant reactions.* | | |
|  | Drug | Reaction |
|  | 1 |  |
|  | 2 |  |
|  | 3 |  |
|  | 4 |  |
|  | 5 |  |
| *Recent medications that caused problems or didn’t work.* | | |
|  | Drug | Problem |
|  | 1 |  |
|  | 2 |  |
|  | 3 |  |
|  | 4 |  |
|  | 5 |  |

|  |  |  |
| --- | --- | --- |
| **Medical Team** | | |
| PCP | Name: |  |
| Phone: |  |
| Specialist 1 | Name: |  |
| Phone: |  |
| Specialist 2 | Name: |  |
| Phone: |  |
| Pharmacy | Name: |  |
| Phone: |  |