

Training Family Caregivers in Team-Based Medical Decisions

**Medication List**

|  |  |  |
| --- | --- | --- |
| **Medication Record** | **Patient Name:** |  |

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| --- | --- |
| **As of:** |  |
| **Birth Date:** |  |
| Emergency Contact 1: |  | Phone: |  |
| Emergency Contact 2: |  | Phone: |  |

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| **MEDICATIONS** |
| **Name of Drug** | **1** | **2** | **3** | **4** | **5** | **6** |
| Generic |  |  |  |  |  |  |
| Brand |  |  |  |  |  |  |
| OTC |  |  |  |  |  |  |
| **How medication is administered (pill, capsule, injection, patch, ointment)** |  |  |  |  |  |  |
| **Dosage** |  |  |  |  |  |  |
| **What the 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 the prescription** |  |  |  |  |  |  |
| **Date Started** |  |  |  |  |  |  |
| **Date Stopped** |  |  |  |  |  |  |

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

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| **DRUG 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 |  |  |

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| **MEDICAL TEAM** |
| **PCP** | Name: |  |
| Phone: |  |
| **Specialist 1** | Name: |  |
| Phone: |  |
| **Specialist 2** | Name: |  |
| Phone: |  |
| **Pharmacy** | Name: |  |
| Phone: |  |