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| HCP: | | Insurance: | |
| Name: | DOB: | Last P.E.: | Date: |
| Allergies: | | | |

Reason for Visit / Program Staff Update: This information was updated on:

Medication Update since last visit: (Missed doses, refusals, PRNs given, PRN effectiveness, Self-administration status, etc.)

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| 1. Is the mixture of ALL medications appropriate for this person? Yes No N/A **COMMENTS** 2. Are the medications, doses you are prescribing appropriate and effective? Yes No N/A 3. Any evidence of tardive dyskinesia or any side effects noted? Yes No N/A 4. Are you recommending vital sign monitoring for any medication you are ordering? Yes No N/A   If Yes, Use the Special Instructions on the Health Care Provider Order to indicate vital sign, parameters and when to notify HCP. 5. Any specific steps to be taken if a dose of medication you have ordered is missed? Yes No N/A 6. Any possible adverse, allergic reactions, contraindications specific to this person? Yes No N/A 7. Are there any specific staff responses (when to hold or when to contact HCP)? Yes No N/A |
| HCP Progress Note / Findings / Recommendations: |
| **NOT CAPABLE OF SELF-ADMINISTERING AT THIS TIME** |
| **SELF-ADMINISTRATION TRAINING PLAN**  MAY POUR ONE DOSE UNDER STAFF SUPERVISION BUT CAN NOT HOLD MEDICATIONS  ABLE TO PACKAGE AND SELF-ADMINISTER FOR: 1 dose  1 day  3 days  5 days  7 days  14 days    OTHER: |
| **CAPABLE OF FULLY SELF-ADMINISTERING**  Understands that he/she is responsible for storing medications and taking all medications as ordered Understands the dosage, purpose and common side-effects of all medications prescribed  Understands what might occur if he/she does not take medications as prescribed |
| **Schedule Next Visit Within** 1 month  3 months  12 months or Next Visit Date: |
| **Health Care Provider Signature: Date:** |

**MEDICATIONS ORDERED BY OTHER HEALTH CARE PROVIDERS (Not by above HCP)**

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Posted by: Date: Time:

Verified by: Date: Time: