MEDICATION PROFILE

Patient Name________________________________ ID #______________

Pharmacy Name__________________ Phone #__________ Fax #__________

Height__________ Weight__________ Type of venous access (if applicable)__________________

Allergies: ❍ None known ❍ Yes (if yes, list and explain e.g. rash, hives, swelling)

____

Medications administered by: ❑ Self ❑ Caregiver/Family ❑ Nurse ❑ Other__________________

Mediplanner filled: ❍ No ❍ Yes If yes, by whom__________________ How often__________

Hospice staff orders medications: ❑ N/A ❍ Yes ❍ No If no, __________________

MEDICATIONS (includes all prescription, over-the-counter, herbals and supplements)

Start Date	Stop Date	✓ If Hospice Pays	(N)ew (C)hanged (O)ngoing	Medication and Dose	Route	Frequency/Instructions	Pill Count If Applicable	✓ If High-Risk Drug
		❑	❑ N ❑ 0 ❑ C					
		❑	❑ N ❑ 0 ❑ C					
		❑	❑ N ❑ 0 ❑ C					
		❑	❑ N ❑ 0 ❑ C					
		❑	❑ N ❑ 0 ❑ C					
		❑	❑ N ❑ 0 ❑ C					
		❑	❑ N ❑ 0 ❑ C					
		❑	❑ N ❑ 0 ❑ C					
		❑	❑ N ❑ 0 ❑ C					
		❑	❑ N ❑ 0 ❑ C					
		❑	❑ N ❑ 0 ❑ C					
OXYGEN								
		❑	❑ N ❑ 0 ❑ C	Oxygen _______ ______ LPM	❑ N/C ❑ Trach ❑ Mask	❍ PRN ❍ Continuous		
INFUSION FLUSHES								
		❑	❑ N ❑ 0 ❑ C	Normal saline ______ mL	IV			
		❑	❑ N ❑ 0 ❑ C	Heparin ____ unit/mL ______ mL	IV			
		❑	❑ N ❑ 0 ❑ C	Sterile water ______ mL	IV			

Medication Device(s): Pump (type)__________________ Nebulizer (type)__________________

REVIEW/REVISE AREAS

Review/Revise dates	Date	Comments
1. Potential adverse effects/drug reactions	❍ Yes ❍ No	
2. Significant side effects	❍ Yes ❍ No	
3. Significant drug interactions	❍ Yes ❍ No	
4. Duplicative drug therapy	❍ Yes ❍ No	
5. Potential/actual ineffective therapy	❍ Yes ❍ No	
6. Understands instructions	❍ Yes ❍ No	
7. Needs further instructions	❍ Yes ❍ No	
8. Potential noncompliance issues with drugs	❍ Yes ❍ No	
9. No problems/issues	❑	
Signature/Title		