Training Family Caregivers in Team-Based Medical Decisions

Medication List

Medication Record	Patient Name:	

As of:			
Birth Date:			
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 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						

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

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		

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