(Addendum to Comprehensive Assessment)

MEDICATION PROFILE

Patient Name	Record #	Physician

Allergies	Weight	Height	Medications Administered By:
			☐ Patient ☐ Nurse ☐ Family _____ ☐ Caregiver _____

Pharmacy	Phone	Fax

Date Started	Date Disc.	Medication	Code	Dose/Route	Freq.	Purpose	Potential Side Effects *

Code: N = New C = Changed L/S = Long standing H = Hospice Provided

*Potential Side Effects: See Reverse side

DRUG REGIMEN REVIEW

	1 Date:	2 Date:	3 Date:	4 Date:
A. The patient reports experiencing 1 or more significant side effects to current drug regimen.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
B. Does the patient and/or caregiver demonstrate a knowledge deficit related to current medication use?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
C. Does the patient demonstrate noncompliance with medication use, as prescribed by physician?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
D. Does patient and/or caregiver have any questions related to current medications, including purpose, dosage, or administration?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
E. Have potential adverse effects, significant drug interactions, duplicate/ineffective drug therapy and potential contraindications been identified?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

F. **Describe Problem and Action for any "YES" responses:**

Date:

Date:

Date:

Date:

Date:

Date:

G. ☐ **Medications Reconciled (per agency policy)**

1 Signature/Title	Date	3 Signature/Title	Date
2 Signature/Title	Date	4 Signature/Title	Date

WHITE – Clinical Record YELLOW – In-home Copy

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