Medication Management Form

Next Step in Care
Family Caregivers & Health Care Professionals Working Together

Patient name: _____ Date of birth: _____

Local pharmacy name: _____ Pharmacy phone number: _____

Local pharmacy address: _____

Mail order company name: _____ Company phone number: _____

Name of Medication Brand or Generic	Dosage (mg. units, puffs, drops)	When to take it? Times per day? AM or PM? With meals?	Why take it?	Start Date	Stop Date	Monitoring Required (e.g. lab test every ____ weeks)	Prescribed By	Side Effects / Danger Signs

Over-the-Counter Medications (check all that your family member uses regularly)

- ‰ Allergy relief, antihistamines
- ‰ Antacids
- ‰ Aspirin / other relief for pain, headache, or fever
- ‰ Cold / cough medicines
- ‰ Diet pills
- ‰ Herbals, dietary supplements
- ‰ Laxatives
- ‰ Sleeping pills
- ‰ Vitamins, minerals
- ‰ Other (list below)

_____
_____
_____

  Date this form was updated: _____