Home Health Care Solutions, LLC. Medication Record

Patient: _____ Patient ID#: _____DOB:_____
Physician: _____ Physician Phone: _____
Pharmacy: _____ Pharmacy Phone: _____

ALLERGIES: _____

*** PLEASE REMEMBER TO ADD OXYGEN, WOUND SUPPLIES, IV MEDICATIONS, IV FLUSHES AND THERAPY PAIN RELIEVING GEL.**

New /Old/ Change	Route	Drug Name	Dose	Quantity	Medication Times				Info / Reason Given PRN Reasons	D/C / Change Date
					AM	Mid Day	PM	Bed Time		

*** Notify your Physician or Nurse before taking any Over the Counter Medications. OTC medications could alter the effects of prescribed medications.**

*** If you are unable to take the Physician's prescribed medications, as listed, contact Home Health Care Solutions or your physician.**

☐ **Review of medications for adverse effects and drug reactions, ineffective drug therapy, side effects, duplicate medications, and non-compliance with drug therapy has been performed on: _____(date) by: _____(RN initials)**

☐ **Medication review of current medications the client is taking is requested by: _____ (PT / OT / SLP initials)**

SOC / Follow Up / Recertification					
Signature	**Date**	**Signature**	**Date**	**Signature**	**Date**