Medication Profile

Page ____OF ___

Client Name: Date:

* Include OTC, pain relievers, topicals, vitamins, supplements etc

☐ **Height:** **Weight:**

Status	Date D/C	Medication Name	Dosage	Frequency	Route*	Obtained From	Comments
☐ N ☐ C ☐ L						☐ P ☐ MR ☐ DR ☐ F ☐ Other	
☐ N ☐ C ☐ L						☐ P ☐ MR ☐ DR ☐ F ☐ Other	
☐ N ☐ C ☐ L						☐ P ☐ MR ☐ DR ☐ F ☐ Other	
☐ N ☐ C ☐ L						☐ P ☐ MR ☐ DR ☐ F ☐ Other	
☐ N ☐ C ☐ L						☐ P ☐ MR ☐ DR ☐ F ☐ Other	
☐ N ☐ C ☐ L						☐ P ☐ MR ☐ DR ☐ F ☐ Other	
☐ N ☐ C ☐ L						☐ P ☐ MR ☐ DR ☐ F ☐ Other	
☐ N ☐ C ☐ L						☐ P ☐ MR ☐ DR ☐ F ☐ Other	
☐ N ☐ C ☐ L						☐ P ☐ MR ☐ DR ☐ F ☐ Other	

LEGEND: ***Route =** O-Oral SL-Sublingual TOP-Topical R-Rectal IN-Inhalation P-Patient DR-Doctor F-Family MR-Medical Record O-Other

N-New C-Changed L-Longstanding

Person to call in the event of emergency/relation/phone:

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