Page _____ of _____

(Addendum to Comprehensive Assessment)

MEDICATION PROFILE

Patient Name	Record #	Physician	Phone #

Allergies	Weight	Height

Pharmacy	Phone	Fax

* In the **Potential Side Effects** column write either appropriate Medication Class Reference #, OTC or ALT. *(See canary pages for Medication Classes and associated Side Effects.)*

Medications Administered by: ☐ Patient ☐ Nurse ☐ Family: ____________ ☐ Caregiver: ____________

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

DRUG REGIMEN REVIEW

	Date ▶ 1	2	3	4
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:

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

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

WHITE – Clinical Record **CANARY** – In-home Copy

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