APPENDIX B: Family Caregiver's MEDICATION LIST Form

Keep this list updated and bring it to all doctor visits.

MEDICATION LIST

Patient Name:_____**Age:**_____

Date of this list: _____

ALLERGIES: Medication allergies: _____

_____

Food allergies:_____

_____

Other allergies:_____

CURRENT PRESCRIPTION MEDICATIONS:

1. Medication name: _____

Dose: _____ **Frequency:** _____

Route: □ By mouth □ Patch □ Injection □ Inhaler □ Eye/Ear drops □ Other:

_____

What it is for: _____

Prescribing doctor: _____

Pharmacy: _____

Date started: _____

Special instructions:

_____

_____

2. Medication name: _____

Dose: _____ **Frequency:** _____

Route: □ **By mouth** □ **Patch** □ **Injection** □ **Inhaler** □ **Eye/Ear drops** □ **Other:**

_____

What it is for: _____

Prescribing doctor: _____

Pharmacy: _____

Date started: _____

Special instructions:

_____

_____

3. Medication name: _____

Dose: _____ **Frequency:** _____

Route: □ **By mouth** □ **Patch** □ **Injection** □ **Inhaler** □ **Eye/Ear drops** □ **Other:**

_____

What it is for: _____

Prescribing doctor: _____

Pharmacy: _____

Date started: _____

Special instructions:

_____

_____

4. Medication name: _____

Dose: _____ **Frequency:** _____

Route: □ **By mouth** □ **Patch** □ **Injection** □ **Inhaler** □ **Eye/Ear drops** □ **Other:**

_____

What it is for: _____

Prescribing doctor: _____

Pharmacy: _____

Date started: _____

Special instructions:

_____

_____

5. Medication name: _____

Dose: _____ **Frequency:** _____

Route: □ **By mouth** □ **Patch** □ **Injection** □ **Inhaler** □ **Eye/Ear drops** □ **Other:**

_____

What it is for: _____

Prescribing doctor: _____

Pharmacy: _____

Date started: _____

Special instructions:

_____

_____

OVER-THE-COUNTER MEDICATIONS

Medication name: ____

Dose/frequency: ____

Indications (What for): ____

Medication name: ____

Dose/frequency: ____

Indications (What for): ____

Medication name: ____

Dose/frequency: ____

Indications (What for): ____

Medication name: ____

Dose/frequency: ____

Indications (What for): ____

Medication name: ____

Dose/frequency: ____

Indications (What for): ____

Medication name: ____

Dose/frequency: ____

Indications (What for): ____

Medication name: ____

Dose/frequency: ____

Indications (What for): ____

Medication name: ____

Dose/frequency: ____

Indications (What for): ____

VITAMINS AND SUPPLEMENTS

Name: _____

Dose/frequency: _____

Indications (What for): _____

Name: _____

Dose/frequency: _____

Indications (What for): _____

Name: _____

Dose/frequency: _____

Indications (What for): _____

Name: _____

Dose/frequency: _____

Indications (What for): _____

Name: _____

Dose/frequency: _____

Indications (What for): _____

Name: _____

Dose/frequency: _____

Indications (What for): _____

Name: _____

Dose/frequency: _____

Indications (What for): _____

Name: _____

Dose/frequency: _____

Indications (What for): _____

AS-NEEDED (PRN) MEDICATIONS

Medication name: _____

What it is for: _____

Dose/frequency: _____

When to use: _____

Medication name: _____

What it is for: _____

Dose/frequency: _____

When to use: _____

DISCONTINUED MEDICATIONS (and reason, if known)

Medication name: _____

Date stopped: _____

Reason: _____

Medication name: _____

Date stopped: _____

Reason: _____

Medication name: _____

Date stopped: _____

Reason: _____

PHARMACY INFORMATION:

Pharmacy Name: _____

Phone: _____

Address: _____