[Insert organisation name/logo]

# CLIENT MEDICATION SUMMARY FORM

***Note\****

*All client medication assistance templates should be reviewed by qualified medical personnel before finalising.*

*\*Please delete note before finalising this template.*

This form is to be completed by authorised staff and informed by prescription information provided by the client’s doctor and/or dosage information on the medication packaging.

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| --- | --- | --- | --- |
| **Client name** |  | **Client ID** |  |
| **Staff name/ role** |  | **Date** |  |

|  |
| --- |
| **Known Allergies** |
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|  |  |
| --- | --- |
| **Medication Review** | |
| **Last carried out:** | **Next review due:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medical Practitioner** | | | | |
| **Name of doctor** | **Specialty** | **Contact No.** | **Date of last appointment** | **Date of next appointment** |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Summary of Medications** | | | | | | | | |
| **Name of Medication** | **Prescribed Yes/No**  **If Yes, prescribed by** | **PRN Yes/No** | **Strength** | **Dose** | **Timing** | **Route** | **Start date** | **Due to finish** |
|  |  |  |  |  |  |  |  |  |
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