Individual Medication Record

DRUG SENSITIVITY / ALLERGY:	**Name:** **D.O.B:**	**PHOTOGRAPH**
	Address: **PIN:**	
	Location:	
Name of GP / GP Stamp	**G.P. Signature** **Date:**	
	Review Dates:	
	Please Write MR in Generic Form where possible	

Prescribed Regular Medication

No	Medication	Dose	Route	How Often	Times:24 hour clock						Specific Instruction (e.g. with food/crushed /half tablet)	Psycho-tropic = P Control Drug = C	Start Date	Dr Signature	Stop Date & signature
A												P☐ C☐			
B												P☐ C☐			
C												P☐ C☐			
D												P☐ C☐			
E												P☐ C☐			
F												P☐ C☐			
G												P☐ C☐			
H												P☐ C☐			
I												P☐ C☐			
J												P☐ C☐			
K												P☐ C☐			
L												P☐ C☐			

Client Name:						PIN:							Location			
No	Medication	Dose	Route	How Often	Times:24 hour clock						Specific Instruction (e.g. with food/crushed /half tablet)	Psycho-tropic = P Control Drug = C	Start Date	Dr Signature	Stop Date And signature
M												P☐ C☐			
N												P☐ C☐			
O												P☐ C☐			
P												P☐ C☐			
R												P☐ C☐			

PRN Medications

Client Name:						PIN:			Location			
	Medication	Dose	Route	How Often	Reason for Medication	Specific Instruction (e.g. with food/crushed /half tablet)	Max dosage in 24hr	Medical review required after (doses or time frame)	Start Date	Dr Signature	Stop date and Initials
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											