Next Step in Care
Family Caregivers & Health Care Professionals Working Together

Medication Management Form

Patient name: _____ Date of birth: _____

Local pharmacy name: _____ Pharmacy phone number: _____

Local pharmacy address: _____

Mail order company name: _____ Company phone number: _____

Name of Medication Brand or Generic	**Dosage** (mg. units, puffs, drops)	**When to take it?** Times per day? AM or PM? With meals?	**Why take it?**	**Start Date**	**Stop Date**	**Monitoring Required** (e.g. lab test every _____ weeks)	**Prescribed By**	**Side Effects / Danger Signs**

Over-the-Counter Medications (check all that your family member uses regularly)

- ❑ Allergy relief, antihistamines
- ❑ Antacids
- ❑ Aspirin / other relief for pain, headache, or fever
- ❑ Cold / cough medicines
- ❑ Diet pills
- ❑ Herbals, dietary supplements
- ❑ Laxatives
- ❑ Sleeping pills
- ❑ Vitamins, minerals
- ❑ Other (list below):

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