[Insert organisation name/logo]

# CLIENT MEDICATION SUMMARY

***🖌Note\****

*All client medication administration 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.

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

|  |
| --- |
| **Known Allergies** |
|  |
|  |
|  |
|  |

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

|  |
| --- |
| **Medical Practitioner** |
| **Name of doctor** | **Specialty** | **Contact No.**  | **Date of last appointment** | **Date of next appointment** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |
| --- |
| **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** |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |