Medication Record

Consumer Name: _____ **Page** _____ **of** _____

Allergies: _____ **Physician:** _____ **Physician #** _____

Meds Recorded from Prescription(s) by: _____ **Reviewed by:** _____ **, RN**

Basic Procedures

1. All medication administered must be documented immediately.
2. For a new sheet, complete Consumer Name, Initial Legend, Year & Month.
   a. Fill in Date Prescribed, Medication/Dosage/Route/Frequency/ and Time and initial the date.
3. Any discrepancies should be initialed, circled, and explained on the back.
4. Do not white out, skip lines, leave blank spaces or mark out any information.
5. If you have any medication questions contact your supervisor or the RN.

Initial Legend

Initials	Full Name	Initials	Full Name

Year:	**Month:**	**Days of the Month**																													
Date Prescribed	**Medication, Dosage Route and Frequency**	**Time Given**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**

Ensure the 5 "Rights": the Right Person, the Right Drug, the Right Time, the Right Dose, the Right Route.

Medication Record

MEDICATION DOCUMENTATION:

1. Document routine Medications not administered or administered at a different time.
2. If a medication error occurs, you must contact the RN immediately and complete an Incident Report.

Date	Time	Progress Notes	Initials