

Describe the type of assistance needed for medication. Please **Highlight** the options that apply. More than one can be highlighted.

Completely Independent, understands everything, no assistance needed	Capable of taking them but may choose not to at times.
Understand the medications	Understands the medication but needs a person to remind them.
Someone fills a med box reminder and client take medication	Can be resistive to medication, detailed support plan needed.
Understands the medication but needs technology reminders to take them.	Needs medication but refuses to take it. Health needs extra monitoring with Doctor and Case Manager.

Notes of Assistance:

Are any of the below medications anti-depressants, anti-anxiety, or another type of psychotropic medication? **Yes or No**

Medication Name	Dose	Type (Pill, Liquid, Etc.)	Taken How Many Times of Day	Taken At What Time	Taken for What Reason, Include what diagnosis	How is it taken (with water, in food, etc.)	Any Adverse Effect We Should Look Out For	Who Prescribed This Medication	Is This OTC or RX

Physician's Name _____ Physician's Phone _____ Physician's Fax _____

Physician's Signature _____ Date of Signature _____