NAME: D.O.B: ROOM NO:

HIGH OAKS MEDICATION SUPPORT PLAN

I confirm that I have been involved in the completion of this medication support plan

I understand my care and treatment in relation to medication taken by me.

I have been involved in the risk assessment process and agree with the decision regarding my medication which is

My intended **OUTCOMES** in respect of my medications are:	The **TIMEFRAMES** for this are:

Residents Signature:

Named Team Leader:

Signature of person assisting with the completion of this document:

Print name:

NAME: D.O.B: ROOM NO:

Contents

NAME: D.O.B: ROOM NO:

NAME OF DRUG	DIRECTIONS	CONTRAINDICATORS	ADMIN TIME AND VARIATIONS	SELF / PROMPT OR ADMINISTERED	COMMENTS

NAME: D.O.B: ROOM NO:

Name of GP:

Date of last full medication review:

Date of next full medication review:

Date of last medication risk assessment:

Date of next medication risk assessment: