UNIVERSAL MEDICATION FORM

Patient:

- 1. **ALWAYS KEEP THIS FORM WITH YOU.** You may want to fold it and keep it in your wallet along with your driver's license. Then it will be available in case of an emergency.
- 2. Write down all of the medicines you are taking and list all of your allergies.
- 3. Take this form to ALL doctor visits, when you go for tests and ALL hospital visits.
- 4. WRITE DOWN ALL CHANGES MADE TO YOUR MEDICINES on this form. If you stop taking a certain medicine, draw a line through it and write the date it was stopped. If help is needed, ask your Doctor, Nurse, Pharmacist, or family member to help you to **keep it up-to-date**.
- 5. In the NOTES column, write down the name of the doctor who told you to take the medicine(s). You may also write down why you are taking the medicine (Examples: high blood pressure, high blood sugar, high cholesterol).
- 6. When you are discharged from the hospital, someone will talk with you about WHICH MEDICINES TO TAKE AND WHICH MEDICINES TO STOP TAKING. Since many changes are often made after a hospital stay, a new form should be filled out. When you return to your doctor, take your new form with you. This will keep everyone up-to-date on your medicines.

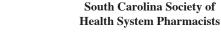
HOW DOES THIS FORM HELP YOU?

- 1. This form helps you and your family members remember all of the medicines you are taking.
- 2. Provides your doctor(s) and others with a **current list of ALL of your medicines**. Doctors need to know the herbals, vitamins, and over-the-counter medicines you take!
- 3. **Helps you**—concerns may be found and prevented by knowing what medicines you are taking.















For copies of the **UNIVERSAL MEDICATION FORM** visit the South Carolina Hospital Association web site at **www.scha.org**.

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Fold this form and keep it in your wallet				Date form started:		
Name:				Address:		
Phone N	umber:					
Birth Date	e:					
Emergen	acy Contact/Phone Nun	nbers:				
Immuni	zation Record (Rec	ord the date	e/year of last dose	taken, if known)		
TETANUS FLU VACC			ACCINE(S)			
PNEUMON	NEUMONIA VACCINE HEPATITIS VACCINE			OTHER		
Allergic	: To / Describe Reac	tion:		Allergic To / Describe Re	action:	
-						
Date	Name of Medication / Dose		Directions: Use patient friendly directions. (Do not use medical abbreviations.)		Date Stopped	Notes: Reason for taking / Doctor Name

Refer to back of form for directions, benefits of using the form, and how to get more copies.

(09/05) Page _____ of ____