

## UNIVERSAL MEDICATION FORM INSTRUCTION SHEET

### Patient's Responsibility

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 your form 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  
St. James Mercy Health System web site at [www.stjamesmercy.org](http://www.stjamesmercy.org).

# UNIVERSAL MEDICATION FORM

Fold this form and keep it in your wallet

Date form started:

Name:	Birth Date:	Address:	Phone Number:
Emergency Contact/Phone numbers:			
IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)			
TETANUS	FLU VACCINE(S)	HEPATITIS VACCINE	PNEUMONIA VACCINE OTHER
Allergic To /Describe Reaction:		Allergic To /Describe Reaction:	

**LIST ALL MEDICINES YOU ARE CURRENTLY TAKING:** prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, ginkgo) Include medications taken as needed (example: nitroglycerin).

**If help is needed, ask your Doctor, Nurse, Pharmacist, or family member to help you to keep your form up-to-date.**

Date	Name of Medication	Dose	Directions <small>Use patient friendly directions. Do not use medical abbreviations</small>	Date Stopped	Notes: Reason for taking	Doctors Name

Name	Birth date	Address	Phone Number:
<b>Allergic To/Describer Reaction:</b>		<b>Allergic To/Describer Reaction:</b>	

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