

# Two-Site Feasibility Test

## DRAFT MEDICATIONS FORM [PCP, RN]

Site ID

Participant ID

**1. Participant Name: [ALL]**

\_\_\_\_\_  
(Last) (First) (MI) (Suffix)

**2. Reason for Assessment: [HEA, PCP, REHAB, SW, RT, RD, PSQ, CSQ]**

- ☐ 1 - Initial assessment  
☐ 2 - Reassessment  
☐ 3 - Annual reassessment

**3. Date Assessment Completed:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ [INTAKE, HEA, PCP, RN, REHAB, SW, RT, RD, EOL, UTIL]  
month day year

Prescription Medications	Date prescription began	Dosage	Frequency	Type of reminder package, if any	Does Participant/ Caregiver know how to administer and the purpose of each medication? <sup>1</sup>		Are participant's medications being administered as prescribed (per Participant or Caregiver report)? <sup>1</sup>		If not taking, reason given.
					Yes	No	Yes	No	
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									
15.									

<sup>1</sup> Indicate **P** for participant or **C** for informal caregiver in the appropriate column.

Over-the-Counter Medications	Date prescription began	Dosage	Frequency	Type of reminder package, if any	Does Participant/Caregiver know how to administer and the purpose of each medication? <sup>1</sup>		Are participant's medications being administered as prescribed (per Participant or Caregiver report)? <sup>1</sup>		If not taking, reason given.
					Yes	No	Yes	No	
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									

Herbal Medications/Preparations	Date began	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			

Home Remedies	Date began	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			

Who provided the information recorded in these tables? **(Mark all that apply.)**

- ☐ 1 - Participant  
☐ 2 - Informal caregiver - Name: \_\_\_\_\_  
☐ 3 - Other - specify: \_\_\_\_\_

Name of informal caregiver who administers participant's medications: \_\_\_\_\_

☐ NA - No informal caregiver or informal caregiver does not administer participant's medications.

Does participant use illicit drugs? ☐ 0 - No ☐ 1 - Yes

Notes (optional): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PROVIDER: Do you have any concerns regarding use of medications or drugs by the participant?

☐ 0 - No ☐ 1 - Yes

If yes, what concerns: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<sup>1</sup> Indicate **P** for participant or **C** for informal caregiver in the appropriate column.