

FIRST PHASE RELIABILITY TEST DRAFT MEDICATIONS FORM

1. **Participant Name:** _____
(Last) (First) (MI) (Suffix)

2. **Reason for Assessment:**

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

3. **Date Assessment Completed:** ____ / ____ / ____
month day year

4. **Staff Member Completing Assessment (Name):** _____
(Last) (First)

5. **Medication Allergies:** Does the participant have allergies to any medications?

- 0 - No
- 1 - Yes - Which medications? _____

Notes (optional): _____

6. **Responsibility for Participant Medications:** Indicate who is routinely responsible for administering medications to the participant. **(Mark all that apply.)**

- 1 - Participant administers medications to himself/herself
- 2 - A family member or other nonpaid caregiver - Name of caregiver: _____
- 3 - A PACE staff member
- 4 - A paid provider who is not affiliated with PACE

7. Does the participant use a medipak provided by (PACE site)?

- 0 - No
- 1 - Yes

Notes (optional): _____

8. Does the participant use illicit drugs?

- 0 - No
- 1 - Yes

Notes (optional): _____

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

- 0 - No
- 1 - Yes

If yes, what concerns: _____

10. Information recorded in the following tables obtained from: **(Mark all that apply.)**

- 1 - Participant
- 2 - Informal caregiver - Name: _____
- 3 - Other (specify): _____

Prescription Medications

Prescription Medications	Associated Diagnosis	Dosage	Frequency	Type of reminder, if any.	Does participant/caregiver know how to administer and purpose of each medication?		Are participant's medications being administered as prescribed?		If not taking, reason given.	Comments
					Yes	No	Yes	No		
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.										
16.										
17.										
18.										
19.										
20.										

Over-the-Counter Medications

Over-the-Counter Medications	Associated Diagnosis	Dosage	Frequency	Type of reminder, if any.	Does participant/caregiver know how to administer and purpose of each medication?		Are participant's medications being administered as prescribed?		Comments
					Yes	No	Yes	No	
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									

Other Medications

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

Home Remedies	Dosage	Frequency	Comments
1.			
2.			
3.			
4.			
5.			
6.			