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| **\*Check Right Participant\* \*Check Right Medication\* MEDICATION RECORD LOG- IYP \*Check Right Strength\* \*Check Right Route\*** |
| AttachParticipantPicture | Participant name (print): | Current Month |  & Year | Date Received: |
| Medication: | Strength: | Doctor name: | Allergies: | Time Received: |
| Method of administration: \_ \_\_Oral, \_\_\_Topical, **\_**\_Inhalant, \_\_\_Ear, \_\_\_Eye | Special Procedures/Instructions (ex. take w/ food, do not crush):  | Amt. Received(count): |
| STICKER- Px initials/ container # | Directions (as on label): | Side Effects/ Precautions, list top 3 (ex/ rash. Drowsiness): | Received Fr.(name): |
|  | Participant Signature: | Staff Receiving: |
| Reason (for meds): | Participant Initial: |
| **Highlight specific**  **time(s)** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
| Morning | Time **7:30AM**Quantity\_\_\_\_ | A |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| B |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| C |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| D |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Afternoon | Time **1:00PM**Quantity \_\_\_\_ | A |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| B |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| C |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| D |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Evening  | Time **6:00PM**Quantity \_\_\_\_ | A |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| B |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| C |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| D |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Bedtime  | Time 9**:00PM**Quantity  | A |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| B |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| C |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| D |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A-Staff initials (2), verifying actions | B- Px initials verifying medication | C- Remaining Count | D- Codes |
| **Codes: R-refusal, SE-side effects, ∅-no side effects, OH-out of house, O-not given,** **X-not to be given \*Note on back when side effects or not given occurs.** |

Medications are to be given at the designated time.

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| **ONCE DAILY** **one of the following times**: | **TWICE DAILY** | **THREE TIMES DAILY:** | **FOUR TIMES DAILY:** |
| 7:30am | 1:00pm | 6:00pm | 9:00pm | 7:30am | 6:00pm | 7:30am | 6:00pm | 9:00pm | 7:30am | 1:00pm | 6:00pm | 9:00pm |
|  | **Check Box** if providingAS NEEDED MEDICATIONSwhich may be given outside the designated timeframes at the participants request and in accordance with the prescription label |

If a medication cannot be given at the designated time it is allowable to give the medication in a time frame of 1 hour before and 1 hour after the indicated time, otherwise it is considered a medical error and a CCC Report is required. When you participate in any documentation for this medication provide your printed name and signed initials on reverse side.

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| Weekly Reviews: Reviewer Signature/Title | Date: | Weekly Reviews: Reviewer Signature/Title | Date: |
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| \_\_\_ Controlled\_**\_**\_ Non-Controlled(check one)  | **Controlled Substance Shift-To-Shift Inventory** (complete each shift for controlled medications) **Non-controlled Weekly Inventory** (complete a weekly count as indicated on the shaded days/shifts for non-controlled medications)  |
|  | Participant Name: | Medication Name: | Strength: |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
| Overnight | Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Count |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 Staff |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Day | Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Count |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 Staff |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Evening | Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Count |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 Staff |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Medication verification:** Contact pharmacy to verify accuracy. | Completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Name of verifier at pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Staff initials, verification** - Any staff assisting with or verifying medication must print and place their initials below. |
| Staff Name: (print) | Initial | Staff Name: (print) | Initial | Staff Name: (print) | Initial | Staff Name: (print) | Initial |
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Rev. 3/06, 6/06, 10/06, 2/07, 7/07, 10/07, 9/08, 2/10, 11/10, 3/12, 7/12 , 4/13, 5/16 F-PR-1215