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| **\*Check Right Participant\* \*Check Right Medication\* MEDICATION RECORD LOG- IYP \*Check Right Strength\* \*Check Right Route\*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Attach  Participant  Picture | | | | | 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): | | | | | |
| Reason (for meds): | | | | | | | | | | | | | | | Participant Signature: | | | | | | | | | | | | | | | | | Staff Receiving: | | | | | |
| 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 **6:30AM**  Quantity\_\_\_\_ | A |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | | |  |  |  |  |  | | |  |  |  |  |  | |  |  |  | |  |  |  |  |  |
| B |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | | |  |  |  |  |  | | |  |  |  |  |  | |  |  |  | |  |  |  |  |  |
| C |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | | |  |  |  |  |  | | |  |  |  |  |  | |  |  |  | |  |  |  |  |  |
| D |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | | |  |  |  |  |  | | |  |  |  |  |  | |  |  |  | |  |  |  |  |  |
| Afternoon | Time **1:00PM**  Quantity \_\_\_\_ | A |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | | |  |  |  |  |  | | |  |  |  |  |  | |  |  |  | |  |  |  |  |  |
| B |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | | |  |  |  |  |  | | |  |  |  |  |  | |  |  |  | |  |  |  |  |  |
| C |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | | |  |  |  |  |  | | |  |  |  |  |  | |  |  |  | |  |  |  |  |  |
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| Evening | Time **6:00PM**  Quantity \_\_\_\_ | A |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | | |  |  |  |  |  | | |  |  |  |  |  | |  |  |  | |  |  |  |  |  |
| B |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | | |  |  |  |  |  | | |  |  |  |  |  | |  |  |  | |  |  |  |  |  |
| C |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | | |  |  |  |  |  | | |  |  |  |  |  | |  |  |  | |  |  |  |  |  |
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| Bedtime | Time 9**:00PM**  Quantity \_\_\_\_ | A |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | | |  |  |  |  |  | | |  |  |  |  |  | |  |  |  | |  |  |  |  |  |
| B |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | | |  |  |  |  |  | | |  |  |  |  |  | |  |  |  | |  |  |  |  |  |
| C |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | | |  |  |  |  |  | | |  |  |  |  |  | |  |  |  | |  |  |  |  |  |
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| 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:** | | | |
| 6:30am | | 1:00pm | 6:00pm | 9:00pm | 6:30am | 6:00pm | 6:30am | 6:00pm | 9:00pm | 6:30am | 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 |  |  |  | |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Evening | Time |  |  |  | |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Count |  |  |  | |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 Staff |  |  |  | |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Medication verification:** Contact pharmacy to verify accuracy. | Completed \_\_\_ | 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 , 10/12, 4/13, 5/16 F-PR-1314