MEDICATION LIST

Patient Name: _____ Today's Date: _____

(Please check one box below)

□ Not currently taking any medications

□ Currently taking medications, please list below:

Drug Name	Dosage	Frequency (how many & how often)	Route of Administration (oral or injection)

MEDICARE PATIENTS ONLY:

Therapy Services:

Have you had **ANY** therapy services elsewhere this year? Yes □ No □

If Yes, when? _____ **Have you been discharged?** Yes □ No □

Home Health:

Is anyone coming to your home to provide healthcare services? Yes □ No □

Nurse □ Home Health Aide □ Therapy Services □

If Yes, when? _____ **Have you been discharged?** Yes □ No □