

Partners in Recovery

MEDICATION OBSERVATION FORM

CLIENT NAME: _____

Date	Time	Did you observe client taking all medications listed below as prescribed? Comments	Location	Staff Initials/ Credential	Client Initials
	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Yes; Comment: _____ <input type="checkbox"/> No; Comment: _____	<input type="checkbox"/> Home <input type="checkbox"/> Other _____		
	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Yes; Comment: _____ <input type="checkbox"/> No; Comment: _____	<input type="checkbox"/> Home <input type="checkbox"/> Other _____		
	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Yes; Comment: _____ <input type="checkbox"/> No; Comment: _____	<input type="checkbox"/> Home <input type="checkbox"/> Other _____		
	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Yes; Comment: _____ <input type="checkbox"/> No; Comment: _____	<input type="checkbox"/> Home <input type="checkbox"/> Other _____		
	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Yes; Comment: _____ <input type="checkbox"/> No; Comment: _____	<input type="checkbox"/> Home <input type="checkbox"/> Other _____		
	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Yes; Comment: _____ <input type="checkbox"/> No; Comment: _____	<input type="checkbox"/> Home <input type="checkbox"/> Other _____		

List of Current Medications as of MM/DD/YR:

Medication Name	Dosage/Route	Prescriber
1)		
2)		
3)		
4)		
5)		

Observing Staff Name/Initials:

_____ / _____	_____ / _____
_____ / _____	_____ / _____
_____ / _____	_____ / _____

Form Date 12.03.07

Partners in Recovery

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Medication Name	Dosage/Route	Prescriber
1)		
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Observing Staff Name/Initials:

_____ / _____	_____ / _____
_____ / _____	_____ / _____
_____ / _____	_____ / _____

Form Date 12.03.07