"UNIVERSAL MEDICATION FORM"

Fold this form and keep it in your wallet/purse

HOW DOES THIS FORM HELP YOU?

- I. This form helps you and your family members remember all of the medicines you are taking.
- II. This form provides your doctor(s) and others with a current list of <u>ALL</u> of your medicines (example: nitroglycerin), including the herbals (examples: ginseng, gingko), vitamins, and over-the-counter medicines (examples: aspirin, antacids) you take.



To Our Valued Patients:

- 1. ALWAYS KEEP THIS FORM WITH YOU. You may want to fold it and keep it in your wallet along with your driver's license. Then it will be available in case of an emergency.
- **2.** WRITE DOWN ALL OF THE MEDICINES you are taking and list all of your allergies.
- 3. TAKE THIS FORM TO ALL DOCTOR VISITS, WHEN YOU GO FOR TESTS AND ALL HOSPITAL VISITS.
- 4. WRITE DOWN ALL CHANGES MADE TO YOUR

 MEDICINES on this form. If you stop taking a certain medicine, draw a line through it and write the date it was stopped. If help is needed, ask your

stopped. If help is needed, ask your Doctor, Nurse, Pharmacist, or family member to help you to keep it up-to-date.

- 5. In the NOTES column, WRITE DOWN THE NAME OF THE DOCTOR who told you to take the medicine(s). You may also write down why you are taking the medicine (Examples: high blood pressure, high blood sugar, high cholesterol).
- 6. When you are discharged from the hospital, someone will talk with you about WHICH MEDICINES TO TAKE AND WHICH MEDICINES TO STOP TAKING. Since many changes are often made after a hospital stay, a new form may be filled out. When you return to your doctor, take your most current form with you. This will keep everyone up-to-date on your medicines.





For copies of the UNIVERSAL MEDICATION FORM, visit: www.OwensboroHealth.org

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Know Your Medicines: "UNIVERSAL MEDICATION FORM"



Fold this form and keep it in your wallet/purse Date form started: MY Personal Information: Name: Street Address: _____ City/State: _ Zip Code: _____ Phone: _ Birth Date: __/__ Physicians: _ MY Emergency Contact/Phone Numbers: MY Immunization Record: (Record the date/year of last dose taken, if known) TETANUS: _ FLU VACCINE(S): _ PNEUMONIA VACCINE:_ HEPATITIS VACCINE: ___ OTHER:_ Allergies? Describe reaction(s):

MY MEDICATION Information:

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING:

Prescription medicines (example: nitroglycerin), including the herbals (examples: ginseng, gingko), vitamins, and over-the-counter medicines (examples: aspirin, antacids) you take.

DATE:	NAME OF MEDICATION/DOSE:	DIRECTIONS: (No abbreviations) Use patient friendly directions.	DATE STOPPED:	NOTES: Reason for taking/ Doctor Name
				7.040000 1.44 1.010 4.4505 0037700

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UNIVERSAL MEDICATION FORM

To Our Valued Patients:

5

Medicines

- 1. ALWAYS KEEP THIS FORM WITH YOU. You may want to fold it and keep it in your wallet along with your driver's license. Then it will be available in case of an emergency.
- 2. WRITE DOWN ALL OF THE MEDICINES you are taking and list all of your allergies.
- 3. TAKE THIS FORM TO ALL DOCTOR VISITS, WHEN YOU GO FOR TESTS AND ALL HOSPITAL VISITS.
- 4. WRITE DOWN ALL CHANGES MADE TO YOUR **MEDICINES** on this form. If you stop taking a certain medicine, draw a line through it and write

the date it was stopped. If help is needed, ask your Doctor, Nurse, Pharmacist, or family member to help you to keep it up-to-date.

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Know Your Medicines:



Name:Street Address:	Fold this form and keep it in your wallet/purse	Date form started:
City/State: Zip Code: Phone: Birth Date: _/ _/ Physicians: MY Emergency Contact/Phone Numbers: MY Immunization Record: (Record the date/year of last dose taken, if known) TETANUS: FLU VACCINE(S):	MY Personal Information:	
Birth Date:/ Physicians:		
MY Immunization Record: (Record the date/year of last dose taken, if known) TETANUS: FLU VACCINE(S):	City/State: Physicians:	Zip Code: Phone:
TETANUS: FLU VACCINE(S):	MY Emergency Contact/Phone Numbers:	
		•
OTHER: HEPATITIS VACCINE	PNEUMONIA VACCINE:OTHER:	
Allergies? Describe reaction(s):	Allergies? Describe reaction(s):	
	MY MEDICATION Information:	

DATE:	NAME OF MEDICATION/DOSE:	DIRECTIONS: (No abbreviations) Use patient friendly directions.	DATE STOPPED:	NOTES: Reason for taking/ Doctor Name
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