NAME: D.O.B: ROOM NO:

HIGH OAKS MEDICATION SUPPORT PLAN

I **SERVICE USER** confirm that I have been involved in the completion of this medication support plan

I understand my care and treatment in relation to the medication taken by me.

I have been involved in the risk assessment process and agree with the decision regarding my medication which is currently I will (STATE LEVEL OF SUPPORT)

My intended **OUTCOMES** in respect of my medications are:	The **TIMEFRAMES** for this are:

SERVICE USERS Signature:

Named EMPLOYEE:

Signature of person assisting with the completion of this document:

Print name:

Contents of Medication Support Plan

NAME: D.O.B: ROOM NO:

NAME and DOSAGE OF DRUG/S	Admin directions /time and variations	SPECIFICS AROUND WITH FOOD / ON EMPTY STOMACH ETC

DRUG	SPECIFC SIDE EFFECTS OR POSSIBLE CONTRAINDICATORS
RISK LEVEL OF DRUG	**REASON FOR PERCIEVED RISK**

NAME: D.O.B: ROOM NO:

KEY::

S.A = RESIDENT TO SELF ADMINSTER

Pmpt = RESIDENT TO PROMPT

Admin = NURSE TO ADMINISTER

S.A	Pmpt	Admin	Risk level	Justification for risk	Variables / Special instructions

Name of GP:

Date of last full medication review:

Date of next full medication review:

Date of last medication risk assessment:

Date of next medication risk assessment: