**This document must only be completed by a medical practitioner**. This is a record of all medications past, ceased and currently prescribed. This record provides a checking tool to ensure medications are current.

LWB Staff must not record (*transcribe*) a person’s prescribed medications or their doses into this document.

| **Medication Record** | **Page**      **of**       |
| --- | --- |
| **Name:** |       | **Address:** |       | **D.O.B** |       |
| **CIRTS ID** |       |
| **To be completed by the client’s GP or Specialist only** |
| Date | Medication | Dose | Freq. | Route | Reason for medication being prescribed | Date of review  | Doctor’s name (printed) | Doctor’s signature | Date medication ceased | Reason ceased | Doctor’s signature |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |

**This document must only be completed by a medical practitioner**. This is a record of all medications past, ceased and currently prescribed. This record provides a checking tool to ensure medications are current.

LWB Staff must not record (*transcribe*) a person’s prescribed medications or their doses into this document.

| **Medication Record** | **Page**      **of**       |
| --- | --- |
| **Name:** |       | **Address:** |       | **D.O.B** |       |
| **CIRTS ID** |       |
| **To be completed by the client’s GP or Specialist only** |
| Date | Medication | Dose | Freq. | Route | Reason for medication being prescribed | Date for review  | Doctor’s name (printed) | Doctor’s signature | Date medication ceased | Reason ceased | Doctor’s signature |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |
|       |       |       |       |       |       |       |       |  |       |       |  |