QUINTE HEALTH CARE
SELF MEDICATION RECORD

Patients:

Please record the time that each medication is taken, with a.m. or p.m. noted and the number of tablets, puffs or drops taken.

Please sign and return this form to your nurse when you are discharged or the form is filled.

If you have questions about your medications or how to take them, please speak to your nurse.

Date of Initiation ____________________________ **ALLERGIES:** _________________________

MEDICATION DOSAGE & DIRECTIONS	DATE ____________		DATE ____________		DATE ____________		DATE ____________	
	Time	Amount	Time	Amount	Time	Amount	Time	Amount
Medication: _________________________								
Directions: _________________________								
_________________________								
_________________________								
Maximum:								
_________________________								
Medication: _________________________								
Directions: _________________________								
_________________________								
_________________________								
Maximum:								
_________________________								

Patient Signature on Discharge ____

QHC# 729 (February 2019)