IMS Home Health Care, Inc.
MEDICATION PROFILE

Patient:_____ MR#_____ Cert: _____to_____ SOC / ROC / RC / SCIC Ht. _____ Wt _____lbs

Pharmacy:_____ Phone: _____ Allergies: _____

Date	N / Δ / D/C	Medication / Strength	Indication	Dose	Route	Freq.	MD	Nurse

	SIGNATURE/TITLE	DATE

MD'S who have prescribed medications

1.	3.
2.	4.

DRUG REGIMEN REVIEW: Is the patient compliant with drug therapy: ☐ Yes ☐ No
SIDE EFFECTS: Does Patient report experiencing one or more significant side effects due to drug regimen? ☐ Yes ☐ No
DRUG INTERACTION REVIEW: Potential adverse effects, duplicate/ineffective drug therapy, contraindications identified, & duplication of drug therapy? ☐ Yes ☐ No

White copy: Data Entry Yellow copy: QA Nurse Pink copy: Patient Home Folder

F:/Ims/FORMS/Medication Profile Revised 05-22-08

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