MEDICATION SUPPORT PLAN FOR

Plan developed by:	Signature:	Date of review:

[Form-1019]

REASON FOR PLAN: (Describe reasons why the person requires a support plan)

For example, Don needs help remembering to take his medication. Please remind him each time a medication is due.

IMPORTANT THINGS TO REMEMBER TO KEEP ME SAFE:

(List any additional plans to the person has that may relate to medication)

For example:

- *Don needs to use thickened fluids to swallow medication – read the Mealtime Support Plan to know how to support him to take oral medication.*
- *Don has a health action plan related to the following medication: Ventolin – read the Asthma Action Plan to know how to support him.*

MY MEDICATION LIST: (List both prescribed and PRN medications)

My prescribed medication

For example:

Medication	How it is taken	Where it is kept	Notes: e.g. • Taken with or without food • Stored at certain temperature
Digoxin	By mouth. Don likes to have it with his coffee	Blister Pack	Nil

MY PRN (as needed) medication:

For example:

Medication	Purpose	Indications for use	How is it taken	Where is it kept	Notes e.g
Ventolin	Asthma	• Wheeze • Short of breath • Don asks for it	Puffs. Don can do this himself.	Don has one in his backpack and there are spares in the medication cupboard.	When one finishes, encourage Don to buy a new one at the pharmacy. Ventolin is part of Don's Asthma Action Plan.