

Month/Year _____

Agency _____

Member Name _____

Pharmacy _____

Physician _____

Psychiatrist _____

VITAL SIGNS: BP _____ Heart Rate _____ Respiratory Rate _____ Temp _____

PAIN SCALE

0	1	2	3	4	5	6	7	8	9	10
No Pain			Moderate					Worst		

Side Effects/Interactions:

Allergies:

Medication Adherence Issues:

Nurse's Recommendations:

Follow-up with Physician Needed: Yes No

Scheduled: _____

Other Monthly Visits and Purpose

Date	Med Set	Other	Nurse Initials	Consumer Initials

Nurse's Signature _____

Date: _____

Member's Signature _____

Date: _____

