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: ______________

Medication List

Date: ______________________ Member: ____________________ Nurse: ________________________

Medication	Dose/Frequency	Issues

Other Comments:

____

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____

____

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Medication List

Date: ______________________ Member: ____________________ Nurse: ______________________

Medication	Dose/Frequency	Issues

Other Comments:

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Medication List

Date: ______________ Member: ______________ Nurse: ______________

Medication	Dose/Frequency	Issues

Other Comments:

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