PEI PharmaCheck™

PERSONAL MEDICATION RECORD

PRINT

PERSONAL MEDICATION RECORD OF:

DOB PHN

MEDICATION ALLERGIES, INTOLERANCES, OTHER ALLERGIES

PHARMACY CONTACT INFORMATION

Phone FAX

FAMILY DOCTOR/PRESCRIBER CONTACT INFORMATION

Phone FAX

Name of medication Brand/Generic	**Strength/Dose**	**How to take this medication** (frequency, time of day, etc.)	**Purpose**	**Comments**	**Prescriber**

Accuracy of this list is dependent on the truthfulness and completeness of information provided by the patient and it remains at all times the patient's responsibility to advise their pharmacist of any change to their medications. By signing this, I consent for my pharmacist to share this medication list with my other health care professionals (present and future) to enhance seamless continuity of care.

Patient name Patient signature PharmaCheck follow up required? ◯ Yes: Date/time ◯ No

Additional Comments/Actions Needed:

Pharmacist name Pharmacist signature Date

Canadian Pharmacists Association / Association des pharmaciens du Canada

Prince Edward Island Pharmacists Association