Self-Medication Administration Assessment & Checklist

Self-Medication Administration Assessment

Resident Name: _____ Date: _____				
Able to DO:	**Yes**	**No**	**Assist**	**Comments:**
Tell time				
Distinguish colors				
Match colors				
Distinguish shapes				
Match shapes				
Read prescription label				
Ask staff for medication				
Remove medication from card				
Physically able to take own medications				
Psychologically able to take own medications				
Resident chooses to take own medications				

Current Medications: _____

_____

_____

Plan for Assistance:

_____

_____

_____

Physician's Order _____ Agrees _____ Disagrees _____

Physician's Name _____ Date _____

Nurse's Signature _____ Date _____

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***Must match medication bottle/ label**

State correctly for EACH scheduled AND PRN medication:
1. Medication name
2. Medication dose
3. Reason/ purpose for taking medication
4. Dose per day
5. Route of medication
6. Schedule/ time of day medication is taken
7. Any special instructions (if applicable)
8. Report to care staff after taking medications

Must ALSO supply, handle pick-up, delivery of all medications.

Resident must be assessed by the nurse for full evaluation of the above items for qualifying to be a self-medicator of one or more medications PRIOR to self-medicating in facility.

Answer Example:
1. Metoprolol
2. 50mg tablet
3. Heartbeat regularity
4. Once a day
5. By both swallow whole
6. Morning
7. Take with food