Form No: 03-3-314 **MDS COMPLIANCE AIDS / DOSSETTE BOXES - *MAR CHART***

SERVICE USER: ______________________ Address: ____ Date of Birth: __________ **G.P.**: ______________

	Week Commencing: _____________								Week Commencing: _____________								Week Commencing: _____________								Week Commencing: _____________						
	Sign to confirm that the medication in the pack has been checked against list below: *Signature: ____________ Date: _______*								Sign to confirm that the medication in the pack has been checked against list below: *Signature: ____________ Date: _______*								Sign to confirm that the medication in the pack has been checked against list below: *Signature: ____________ Date: _______*								Sign to confirm that the medication in the pack has been checked against list below: *Signature: ____________ Date: _______*						
TIME	M	T	W	Th	F	S	Su		M	T	W	Th	F	S	Su		M	T	W	Th	F	S	Su		M	T	W	Th	F	S	Su
Morning																															
Lunch																															
Teatime																															
Evening																															
Special Instructions:																															

Codes if medication not taken: A = already taken P = prepared to be taken later D = declined and destroyed V = nausea or vomiting X = missing from dossette box O = OTHER *(specify on back of Chart)*

CONTENTS OF PHARMACY PREPARED DOSSETTE BOX					
Medicine / Drug	Strength	Dose	Frequency of Dose	Time(s)	Route

CONTRA-INDICATIONS TO MEDICATION
DRUG ALLERGIES:
CULTURAL / ETHNIC CONSIDERATIONS *(e.g. gelatin capsules)*:

DO NOT COPY