

A: SERVICE USER DETAILS					
Surname:		First Name(s):		Title:	
Age last birthday:		Date of Birth:		SERVICE USER REF:	

B: MEDICATION DETAILS			
	Name of Medicine	Type (tablets, capsules, creams etc)	Dosage Instructions
A			
B			
C			
D			

C: SERVICE USER ASSESSMENT					
	RISK ELEMENT	Assessed	Date	Verified	Date
1	Service User understands his / her medication and its purposes				
2	Service User is able to read and UNDERSTAND instructions on medicine containers				
3	Service User is physically able to open tablet bottles / containers and remove medication				
4	Service User is physically able to "pop" tablets through blister strips to remove medication				
5	Service User is able to use eyedrops / ear drops				
6	Service User is able to use creams, ointments and lotions				
7	Service User is able to use inhalers				
8	Service User is able to self-inject safely				
9	Service User understands the need to dispose of needles safely in sharps containers				
10	Service User is able to remember when to take medication				
11	Service User is able to safely manage any changes in medication				