MEDICATION SHEET

DIABETES EDUCATION CENTRE

Medication Allergies: ❒ No
❒ Yes _____

_____

Unit No
Name
Address
Sex D.O.B.
HC No.
Phone number: (h) _____
(w) _____

Instructions:

- See Flow Sheet for insulin and oral anti-hyperglycemic agents (OAA).
- **Update this list at least annually. Provide signature and initial at bottom of the page. Initial all entries.**
- Initial visit: Date and record all pertinent med information (including dosage and frequency). Include over the counter (OTC) medications and supplements. Pay particular attention to aspirin. **Initial.**
- Subsequent visits: Add new meds and **(√)** New Med column. For dose changes to existing meds, **date** Dose change (▲) column (use current visit date), indicate new dosage, and **initial**. If med has been D/C, **(√)**, **date** (use current visit date), and **initial.**

Date (d/m/y)	Medication	Dosage & Freq.	*In	Dose ▲ (date)	Dose ▲ (date)	Dose ▲ (date)	D/C (√) (date)	New Med (√)
	Example:							
	Aspirin ❒ No (*81 to 325 mg/day*) ❒ Yes							

*In = Initial; Sig = Signature

Sig/In: _____ Sig/In: _____ Sig/In: _____

Date (d/m/y)	Medication	Dosage & Freq.	*In	Dose ▲ (date)	Dose ▲ (date)	Dose ▲ (date)	D/C (√) (date)	New Med (√)

*In = Initial; Sig = Signature

Sig/In: _____ Sig/In: _____ Sig/In: _____