Pre-Admission Medication Form

Client Name: ____

D.O.B: ____

Client Allergies: Nil/Yes If yes, specify: ____________________

Date: ______________________

Doctors Name: __________________________________

Doctors Prescriber #: __________________________________

Doctors Contact #: __________________________________

Doctors Signature: __________________________________

***NOTE TO PRESCRIBING DOCTOR:** Please sign the column for each medication. Include all medications, vitamins, and non-prescription medications. Please note that the client will require sufficient prescriptions for 4 weeks upon entry to the program.

Date Commenced	Medication & Strength	Dose	Times taken (e.g. 7am)	Notes	Doctors Signature*	Date Ceased (Dr Intial)