North Texas Infectious Diseases Consultants,P.A.

Universal Medication List

(Include all herbals, prescription, and non-prescription medications, supplements, eye drops, patches, inhaler, etc.)

Information provided by: Patient Family Friend Other:_____ : Unable to attain due to: Patient condition Patient's lack of knowledge of medications

Allergies: _____ Latex☐ Tape ☐ Iodine ☐

Patient Name: _____ Patient date of birth: _____

Pharmacy Name: _____ Pharmacy Phone # : _____

Physician Instructions		Drug Name and Dose (Avoid abbreviations of any kind)	Route		Frequency (Avoid abbreviations)	Last Taken date/time	Nurse Initials	
Continue	Do Not Take		By Mouth ✔	Other (i.e. patch, rectal, etc.)			Approximate Date Started	Prescribing Physician
		Example: Biaxin 500 milligrams	✔		2 daily	today / 8am	3/07	Jones

List completed upon admission by: _____ Date: _____
Patient / Nurse

Prescription Given ✔	New/Changed Drug Name and Dose (Avoid abbreviations of any kind) Indication may be included if needed	Route		Frequency (Avoid abbreviations of any kind)		Instructions given on medication, dose, frequency, side effects, next dose	
		By Mouth ✔	Other (i.e. patch, rectal, etc.)			Next Dose	Nurse Initials

Pt. Follow-up Instructions: _____

The listed medications are correct. I, the undersigned, have read and understand these instructions. I understand if prescriptions are to be filled, I will do this at the pharmacy of my choice ***Do not take any other medication not listed on this sheet.***

Signature of Patient or Authorized Representative Date

Signature of Nurse Reviewing Medication List Date