Appendix B: Medication Support Care Plan

Part A

Responsibility for ordering, transporting, storing and disposing of medicines.

NAME		**DOB**	
ADDRESS:			
GP: Surgery: Telephone: Email:		Pharmacy: Address: Telephone: Email:	
Person responsible for ordering prescriptions Name: Address: Telephone: Email: Has their agreement been confirmed?		**Person responsible for transporting prescriptions** Name: Address: Telephone: Email: Has their agreement been confirmed?	
Person responsible for storing medicines Name: Address: Telephone: Email: Has their agreement been confirmed?		**Person responsible for disposal of medicines** Name: Address: Telephone: Email: Has their agreement been confirmed?	

PART B

Supporting people to take their medicines.

1. Support Type required by the service

a) I need reminding to take my medication. Yes/No
b) I need support to take my medication from a cassette. Yes/No
c) I need support to take my medication from original packages Yes/No
d) Other people support me to take my medicine *Yes/No

*If Yes complete box below:-

Description of the support other people provide:-

2. Visits

Complete chart using key chart to identify which visits **involve [INSERT ORGANISATION NAME]** and the type of medicine support the person needs to take their medication.

Key: R = Remind C = from a cassette OP = Original packages

	MORNING	NOON	TEATIME	EVENING
MONDAY				
TUESDAY				
WEDNESDAY				
THURSDAY				
FRIDAY				
SATURDAY				
SUNDAY				

3. Storage

Safe storage arrangements (please indicate)

4. **Allergies**

Does the person have any known allergies? ***How do we respond to an allergic reaction?***

5. **Supporting people to take their medicine**

Explain the nature and extent of support required and how they normally give their consent. ***Ensure that the person's right to independence and dignity is maintained at all time.***

6. **Consent**

I or my representative give permission for [INSERT ORGANISATION NAME] to provide support with my medication as described in this support plan.

Signed:

Date:

If Representative relationship to above:

PART C: Service Users Name:

Only complete when supporting with medicines but not reminding. Insert medicine descriptions including any special conditions e.g. time specific, fridge storage or take an hour before food etc. If there is a combination of storage fill a profile for each type of storage.

Name of medicine, strength and dosage		Tick	Name of medicine, strength and dosage		Tick
	AM			AM	
	LC			LC	
	TC			TC	
	EVE			EVE	
Name of medicine, strength and dosage		**Tick**	**Name of medicine, strength and dosage**		**Tick**
	AM			AM	
	LC			LC	
	TC			TC	
	EVE			EVE	
Name of medicine, strength and dosage		**Tick**	**Name of medicine, strength and dosage**		**Tick**
	AM			AM	
	LC			LC	
	TC			TC	
	EVE			EVE	
Name of medicine, strength and dosage		**Tick**	**Name of medicine, strength and dosage**		**Tick**
	AM			AM	
	LC			LC	
	TC			TC	
	EVE			EVE	