MEDICATION LIST

Name:_____ **Date:**_____

List all current prescription, over the counter, herbals, vitamins/mineral/dietary supplements including name, dosage, frequency, and route of admission (how medication/supplement is taken).

Name of medication/supplement	Dosage	Frequency	Route of admission (How the medication is taken)

I,_____**, have reviewed the above medication list with** _____**.**
(therapist name) **(patient name)**

_____ _____
Therapist Signature **Date**