MEDICATION VERIFICATION

Facility Name:_____Resident Name:_____

Intake date:_____ Date of last visit:_____Date of this visit:_____

All current medications prescribed for this resident are listed below. Please indicate approval of the medications and continuation of the prescribed medications and amounts by signing below your respective column(s). *Please use the other side of this form for additional medications.*

*** Name of Facility Staff member preparing this form:**

PSYCHIATRIC MEDS	**PHYSICAL MEDS**	**OTHER (i.e. - DENTAL)**
Psychiatric Provider Signature/Date	PCP Signature/Date	Other Signature/Date

Provider/case manager COMMENTS:

New medications and/or changes to current orders. ***(To be completed by physician):***

_____/_____

Physician Signature for New Medications or changes to current order Date

PSYCHIATRIC MEDS	PHYSICAL MEDS	OTHER (i.e. - DENTAL)
Psychiatric Provider Signature/Date	PCP Signature/Date	Other Signature/Date

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