**HMI Home Health Division**

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# MEDICATION PROFILE

**PATIENT:** ______________________ **ALLERGIES:** ____________________________________

**PHYSICIAN:** ____________________ **PHYSICIAN PHONE NUMBER:** _____________________

**PHARMACY:** ____________________ **PHARMACY PHONE NUMBER:** _____________________

| DATE | NAME OF DRUG & DOSAGE | FREQUENCY | | ROUTE | | D/C DATE | CLASS |
|---|---|---|---|---|---|---|---|
| | | □ 1X/DAY<br>□ 2X/DAY<br>□ 3X/DAY<br>□ 4X/DAY | □ BEDTIME<br>□ EVERY ___HR<br>□ PNR FOR ____<br>□ __________ | □ PO<br>□ PRN<br>□ IM<br>□ SQ | □ TOP<br>□ TDM<br>□ INH<br>□ IV | | |
| | | □ 1X/DAY<br>□ 2X/DAY<br>□ 3X/DAY<br>□ 4X/DAY | □ BEDTIME<br>□ EVERY ___HR<br>□ PNR FOR ____<br>□ __________ | □ PO<br>□ PRN<br>□ IM<br>□ SQ | □ TOP<br>□ TDM<br>□ INH<br>□ IV | | |
| | | □ 1X/DAY<br>□ 2X/DAY<br>□ 3X/DAY<br>□ 4X/DAY | □ BEDTIME<br>□ EVERY ___HR<br>□ PNR FOR ____<br>□ __________ | □ PO<br>□ PRN<br>□ IM<br>□ SQ | □ TOP<br>□ TDM<br>□ INH<br>□ IV | | |
| | | □ 1X/DAY<br>□ 2X/DAY<br>□ 3X/DAY<br>□ 4X/DAY | □ BEDTIME<br>□ EVERY ___HR<br>□ PNR FOR ____<br>□ __________ | □ PO<br>□ PRN<br>□ IM<br>□ SQ | □ TOP<br>□ TDM<br>□ INH<br>□ IV | | |
| | | □ 1X/DAY<br>□ 2X/DAY<br>□ 3X/DAY<br>□ 4X/DAY | □ BEDTIME<br>□ EVERY ___HR<br>□ PNR FOR ____<br>□ __________ | □ PO<br>□ PRN<br>□ IM<br>□ SQ | □ TOP<br>□ TDM<br>□ INH<br>□ IV | | |
| | | □ 1X/DAY<br>□ 2X/DAY<br>□ 3X/DAY<br>□ 4X/DAY | □ BEDTIME<br>□ EVERY ___HR<br>□ PNR FOR ____<br>□ __________ | □ PO<br>□ PRN<br>□ IM<br>□ SQ | □ TOP<br>□ TDM<br>□ INH<br>□ IV | | |
| | | □ 1X/DAY<br>□ 2X/DAY<br>□ 3X/DAY<br>□ 4X/DAY | □ BEDTIME<br>□ EVERY ___HR<br>□ PNR FOR ____<br>□ __________ | □ PO<br>□ PRN<br>□ IM<br>□ SQ | □ TOP<br>□ TDM<br>□ INH<br>□ IV | | |
| | | □ 1X/DAY<br>□ 2X/DAY<br>□ 3X/DAY<br>□ 4X/DAY | □ BEDTIME<br>□ EVERY ___HR<br>□ PNR FOR ____<br>□ __________ | □ PO<br>□ PRN<br>□ IM<br>□ SQ | □ TOP<br>□ TDM<br>□ INH<br>□ IV | | |
| | | □ 1X/DAY<br>□ 2X/DAY<br>□ 3X/DAY<br>□ 4X/DAY | □ BEDTIME<br>□ EVERY ___HR<br>□ PNR FOR ____<br>□ __________ | □ PO<br>□ PRN<br>□ IM<br>□ SQ | □ TOP<br>□ TDM<br>□ INH<br>□ IV | | |
| | | □ 1X/DAY<br>□ 2X/DAY<br>□ 3X/DAY<br>□ 4X/DAY | □ BEDTIME<br>□ EVERY ___HR<br>□ PNR FOR ____<br>□ __________ | □ PO<br>□ PRN<br>□ IM<br>□ SQ | □ TOP<br>□ TDM<br>□ INH<br>□ IV | | |
| | | □ 1X/DAY<br>□ 2X/DAY<br>□ 3X/DAY<br>□ 4X/DAY | □ BEDTIME<br>□ EVERY ___HR<br>□ PNR FOR ____<br>□ __________ | □ PO<br>□ PRN<br>□ IM<br>□ SQ | □ TOP<br>□ TDM<br>□ INH<br>□ IV | | |

**KEY: PO - MOUTH, PRN - AS NEEDED, IM – INTRAMUSCLER, SQ – SUBCUTANEOUS, TOP – TOPICAL, TDM – TRANSDURMAL, INH – INHALATION, IV - INTRAVENOUS**

Clinician Signature/Date: ____________________ Clinician Signature/Date: ____________________

Clinician Signature/Date: ____________________ Clinician Signature/Date: ____________________

Clinician Signature/Date: ____________________ Clinician Signature/Date: ____________________