TestResident Overview Sheet to the Medication Chart

Date first sent to pharmacy:

Care Home: Eventide
Phone: 04 111 1111
Address: one Beach St
Wellington
Fax:
Email:

Pharmacy: Pharmacy Partners
Address: ARC Pharmacy
1 Pharmacy St

Doctor: Dr Sidney Chambers
Medical Centre: Care Services
Address: 48 Bay St

Resident Details *(use label if available)*

Resident Photo:

Family name: Test
Given name: Theresa
Preferred name:
Date of Birth: 18/05/1926
NHI: ALM0425
Gender: Female
CSC:
Area:
Room no. 1

Height *(cm)*:
Date:
Weight: *Please see separate weight chart*

Allergies

Record Medicine/Other reaction, cause and date of reaction if known, and initial.	Pharmacy notified
p Unable to determine	p
p No known allergies	p
latex	ý
	p
	p
	p

Adverse Reactions

Record Medicine reaction, cause and date reaction of if known, and initial.	Pharmacy notified
p Unable to determine	p
p No known reactions	p
postural hypertension Calcium Channel Blockers	ý
	p
	p
	p

The Resident Overview Sheet must accompany all communication to the pharmacy on resident admission and any changes to allergy or reaction information

Special Medication Considerations

p Cognitive impairment	Other factors:
p Hepatic impairment	
ý Renal impairment	
ý Postural unsteadiness and/or falls risk	
p Swallowing difficulty	

Medication Review Completed

Signature	Date	Notes for next visit/review

Sample signature record is maintained and held in (record physical location):