MEDICATION PROFILE **Paloma Home Health Agency, Inc.**

PATIENT:_____ PHARMACY:_____

PHYSICIAN:_____ PHARMACY ADDRESS:_____

PHYSICIAN ADDRESS:_____ PHARMACY PHONE:_____

PHYSICIAN PHONE:_____ PHYSICIAN FAX:_____

FOOD, DRUG, ENVIRONMENTAL ALLERGIES:_____

Pt #:_____ DOB:_____ HEIGHT :_____ WEIGHT:_____

Has patient had any adverse reactions in the past? ❑ Yes ❑ No List:

DATE	DRUG	DOSE	FREQ	ROUTE	**(N)** NEW OR **(C)**CHANGED	COMMENTS	D/C DATE	SIGNATURE
	OXYGEN			At: ____LPM via ❑ NC ❑ Mask ❑ Vent ❑continuous ❑ PRN dyspnea ❑ at HS				

SIGN AND UPDATE

❑ By my signature, I have reviewed the medications to identify any potential adverse effects and drug reactions including ineffective drug therapy, significant side effects, significant drug interactions, significant drug and food interactions, duplicate drug therapy, and non-compliance.

SIGNATURE/DATE	SIGNATURE/DATE	SIGNATURE/DATE