

Medicines List:

Helping you keep track of your medicines

My name: _____

My allergies or previous problems:

My emergency contact(s) details:

My GP/specialist contact details:

My pharmacy: _____

My pharmacist(s): _____

My palliative care team (e.g., careworker, nurse):

Organisation _____



Reminders:

- Ask a member of your care team to help you fill out this form.
- Bring this form to any future medical appointments.
- Include non-prescription medicines.

Name of medicine	What it looks like	How much and when	How to take it	Date started	What the medicine is for
Example only	e.g., round, red, blue, white liquid	e.g., one capsule per day	e.g., by mouth, with food, by injection	dd/mm/yy	e.g., pain