Medication Form

Complete this form and attach it to your signed Doctor's Letter. Give both to your hospital care team. Fill out a new form when your prescriptions change and keep an updated version in your Hospital Safety Guide.

YOUR NAME **DATE FORM FILLED**

Important names and numbers

CARE PARTNER	RELATIONSHIP	PHONE
PARKINSON'S DOCTOR		PHONE
PRIMARY CARE DOCTOR		PHONE
PHARMACY		PHONE

I was diagnosed with Parkinson's disease in _____ (year).

Special Considerations

- ☐ I have a deep brain stimulation device.
- ☐ I have a Duopa pump.
- ☐ I have dementia.
- ☐ I get dizzy or feel faint.
- ☐ I have special dietary needs.
- ☐ I have balance issues.
- ☐ I have trouble swallowing.
- ☐ I experience hallucinations or delusions as part of my Parkinson's.
- ☐ I sometimes feel disoriented or confused.
- ☐ Other: _____

I also have the following conditions (list them below):

Medication List (continued on back)

List all medications you are taking for Parkinson's and other conditions, including over-the-counter medications and supplements. See page 27 for an example and more information.

TIME	MEDICATION	DOSE	NOTES

Medication List

Continue listing all medications and supplements here.

TIME	MEDICATION	DOSE	NOTES

To print additional copies of the Medication Form, visit Parkinson.org/HospitalSafety.