PARKINSON'S DISEASE

Medication Form

Complete this form, make copies and keep them in your Aware in Care kit. At the hospital, share your completed Medication Form when you are asked to provide a list of medications. Fill out a new form when your prescriptions change and keep an updated version in your kit.

YOUR NAME **DATE FORM FILLED**

Important names and numbers

CARE PARTNER	RELATIONSHIP	PHONE/FAX
PARKINSON'S DOCTOR OR NEUROLOGIST		PHONE/FAX
PRIMARY CARE PHYSICIAN		PHONE/FAX
PHARMACY		PHONE/FAX

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

Special Considerations

If any of the following are checked, please consult the Special Considerations of the Hospital Action Plan booklet in the Aware in Care Kit for more information.

- ☐ I have a deep brain stimulation device.
- ☐ I have Parkinson's disease-related dementia
- ☐ I get dizzy or feel faint.
- ☐ I have special dietary needs.
- ☐ I have a Duopa Pump.
- ☐ 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 in a way that is not normal for my Parkinson's.
- ☐ Other:

I also have the following conditions (check box):

○ COPD	○ Diabetes	○ Hypertension	○ Osteoarthritis
○ Depression	○ Heart Disease	○ Melanoma	○ Other:

Contraindicated medications or allergies:

Aware in Care

Parkinson's Foundation

Medication List

List all medications you are taking for Parkinson's and other conditions, including over-the-counter medications and supplements.

TIME	MEDICATION	DOSAGE	NOTES