Parkinson's Foundation

MEDICATION FORM OF

_____
YOUR NAME HERE

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 this updated version in your kit.

Important names and numbers:

Care Partner _____ Relationship _____ Phone/Fax _____

Parkinson's Doctor or Neurologist _____ Phone/Fax _____

Primary Care Physician _____ Phone/Fax _____

Pharmacy _____ Phone/Fax _____

Basic Information:

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

I have a Deep Brain Stimulation device. ☐ Yes ☐ No

I also have the following conditions (check box):

☐ Constipation ☐ Diabetes ☐ Melanoma ☐ Urinary Incontinence
☐ COPD ☐ Heart Disease ☐ Osteoarthritis
☐ Depression ☐ Hypertension ☐ Other:

Medication List:

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

Medication	Dosage	Frequency/Timing	Condition Treated	Started

The Parkinson's Foundation's ***Aware In Care*** campaign aims to help people with Parkinson's get the best care possible during a hospital stay.
For more information please visit **Parkinson.org/awareincare** or call **1-800-4PD-INFO (473-4636)**.