

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

- | | |
|---|---|
| <input type="radio"/> I have a deep brain stimulation device. | <input type="radio"/> I have balance issues. |
| <input type="radio"/> I have a Duopa pump. | <input type="radio"/> I have trouble swallowing. |
| <input type="radio"/> I have dementia. | <input type="radio"/> I experience hallucinations or delusions as part of my Parkinson's. |
| <input type="radio"/> I get dizzy or feel faint. | <input type="radio"/> I sometimes feel disoriented or confused. |
| <input type="radio"/> I have special dietary needs. | <input type="radio"/> 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.



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