**Participant Name:** **Date of Birth:**

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| **Summary of Doctor Approved Medication (refer to CCF-09 Medication Purpose Form – Doctor Approved)** *E.g. Antibiotic / Panadol Osteo* | | | | | | | | |
| Date  .../.../… | Prescribed Medication  (Use Block Letters) | Restrictive Practice Medication? | Dose | Route | Frequency  (e.g. 2xdaily, 4 hourly, lx3weekly) | Side Effects Displayed by Participant | Review  Date | Discontinued  Date |
| *16/9/24* | *E.g. ANTIBIOTIC* | *No* | *100mg every 12 hrs* | *oral* | *2 x daily am and pm* |  | *n/a* | *3 weeks* |
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| **Allergies (please print in red)** | | | | | | | | |
|  | | | | | | | | |
| **Signature** | | | | | | | | |
| Signature ……………………………………………………………………………….. (team leader / manager) Date:………………………..  Print name……………………………………………………………………………… | | | | | | | | |

This form is a summary of the *CCF-09 Medication Purpose Form – Doctor Approved* used at Intake (do not use CCF-28 Participant Treatment Sheet - Summary of Doctor Approved Medications at Intake).

*Please file this form in the participant’s folder, both as a hard copy and electronically.*