**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.*