Medication Cover Sheet

Patient Medication Record

Patient Name: _____

Date of Birth: _ _/_ _/_ _ _ _

Medical Record Number: _____

Primary Physician: _____

Allergies: _____

Emergency Contact Information

Contact Name	Relationship	Phone Number	Alternate Phone	Notes

Reason for Hospitalization

Provide a concise summary of the events, symptoms, or conditions that led to the patient's hospitalization:

_____

_____

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Neuro Status

How do the patient's seizures present and how frequently do they occur?

_____

_____

_____

_____

_____

Seizure Rescue Medications: _____

Mental Status	Level of Consciousness	Motor Function	Sensory Function	Notes

Tracheostomy Information

Tube Type	Size	Cuff Status	Humidification	Suction Frequency	Care Instructions

Respiratory Vent Baseline Settings

Setting Type	Baseline Value	Device/equipment	Notes
Simv			
Oxygen			
Peep			
Rate			
Pressure Control			

Pressure			

Respiratory Treatment

Treatment Type	Medication/Device	Frequency	Duration	Notes

G Tube Information

G Tube Feeding Schedule:

_____

_____

Type	Size	Feeding Formula	Rate	Flush Volume	Care Instructions

Medication List

Medication Name	Dosage	Frequency	Route	Prescribing Doctor	Time

Notes

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