INSTRUCTIONS:

1. Write down all of the medicines you are taking, list all of your allergies and complete your immunization record.
2. Take this form to ALL doctor visits, when you go for tests and ALL Hospital and Emergency Room visits.
3. WRITE DOWN ALL CHANGES MADE TO YOUR MEDICINES on this form. If you stop taking a certain medicine, write the date it was stopped. If help is needed, ask your doctor, nurse, pharmacist, or family member to help you **keep it up-to-date**.
4. In the NOTES column, write down the name of the doctor who told you to take the medicine(s). You may also write down why you are taking the medicine (example: high blood pressure, high blood sugar, high cholesterol).
5. When you are discharged from the hospital, someone will talk with you about **WHICH MEDICINES TO TAKE AND WHICH MEDICINES TO STOP TAKING.** Since many changes are often made after a hospital stay, a new form should be filled out. When you return to your doctor, take your new form with you. This will keep everyone up-to-date on your medicines.

IMMUNIZATION RECORD
Tetanus:
Pneumonia Vaccine:
Flu Vaccine:
Hepatitis Vaccine:
Other:

ALLERGIES/SENSITIVITIES
Medication Name:
Type of Reaction:
When:
Medication Name:
Type of Reaction:
When:
Medication Name:
Type of Reaction
When:
Medication Name:
Type of Reaction
When:

UNIVERSAL MEDICATION FORM

NAME:	
ADDRESS:	
PHONE #:	**BIRTHDATE:**
EMERGENCY CONTACT/PHONE #:	

GRANDE RONDE HOSPITAL
900 Sunset Drive * PO Box 3290
La Grande, Oregon 97850
Phone: 541-963-8421
www.grh.org

PATIENT:

ALWAYS KEEP THIS FORM WITH YOU.

You may want to fold it and keep it in your wallet along with your driver's license. Then it will be available in case of an emergency.

HOW WILL THIS FORM HELP YOU?

1. This form helps you and your family members remember all of the **medicines you are taking.**
2. Provide your doctor(s) and others with a current list of ALL of your medicines. Doctors need to know the herbals, vitamins, and over-the-counter medicines you take!
3. **Helps you**—concerns may be found and prevented by knowing what medicines you are taking.

NAME:_____ **BIRTHDATE:**_____

Addressograph

LIST BELOW ALL OF THE MEDICATIONS THAT YOU ARE TAKING INCLUDING OVER THE COUNTER AND ALTERNATIVE REMEDIES. WRITE IF YOU DON'T KNOW OR CAN'T REMEMBER ALL THE MEDICATIONS THAT YOU ARE TAKING. ALWAYS BRING A LIST OF EVERY MEDICATION YOU TAKE TO EVERY MEDICAL APPOINTMENT, ER VISIT AND HOSPITALIZATION.

Date Start-ed	Medication Name	Dose (How many mg, mcg, etc.)	Route (Mouth, inhaled, in nose)	How often? (Time tak-en, how often per day?)	Date Stopped	(Optional) Notes, Reason for Taking Med, Doctor's Name, etc.
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						

Form filled out by: _____ Reviewed by: _____MD Date: _____

Form filled out by: _____ Reviewed by: _____MD Date: _____

Last Updated: _____ Form filled out by: _____ Reviewed by: _____MD Date: _____