SELF-ADMINISTRATION OF MEDICATIONS

NAME: _____ RESIDENCE: _____

Is the individual able and willing to participate in self medication evaluation? Yes ☐ No ☐ (if yes complete form, if No explain in the Additional Comment section on back of form.)	DATE _____/_____/20_____			
IND = INDPENDENT; ASSIST; UNA = UNABLE TO DO THIS ITEM	**IND**	**ASSIST**	**UNA**	**Comments**
FOR ALL MEDICATION				
1. Individual is able to recognize the time the medication is to be taken (e.g.: tell time, associate with a particular activity etc)				
1a. Individual can recognize the time the medication is to be taken with the assistance of an alarm				
2. Individual can recognize the correct medication container / bottle / blister pack/ medication organizer				
3. Individual can open the correct container /compartment				
4. Individual can remove the correct dose from the container/bottle/blister pack/compartment independently				
5. Individual can close the medication container				
6. Individual can return the medication to the appropriate storage area				
FOR ORAL MEDICATION (place N/A in IND box if not taking oral medications)				
1. Individual can remove the correct number of pills from the container				
1a. Individual can remove the correct amount of medication if it is in a compartment of a medication organizer				
2. Individual can obtain the appropriate fluids or food needed to ingest the medication				
3. Individual can take the medication properly				
FOR TOPICAL MEDICATIONS (place N/A in IND box if not of not taking topical medications)				
1. Individual can prepare site for application (i.e. clean and dry the site etc.)				
2. Individual can apply the appropriate amount of medication on the designated area				
3. Individual can apply dressing to the site (if appropriate)				
4. Individual washes hands after application of topical medication				
OTHER TYPES OF MEDICATION (place N/A in IND box for any route that is not currently being used. . Only evaluate individuals for the types of medications they are taking)				
Individual can apply or administer other types of medications:				
A. Aerosol				
B. Eye				
C. Ear				
D. Rectal				
E. Vaginal				
F. Nasal				
G. Injections SC/IM				
H. Other				

BASED ON OBSERVATION & ASSESSMENT
This individual is capable of the following:

Date ➡	**___/___/20____**				
	Independent	Needs Assistance	Total Support	Not Evaluated	COMMENTS
Oral					
Topical					
Aerosol					
Eye					
Ear					
Rectal					
Vaginal					
Nasal					
Injections SC/IM					
Other					
RN signature					
DATE					

Staff must assist in the administration of any type of medication for which an individual is not assessed as capable of independent self-administration and/or any medication type for which the individual has not been assessed.

Additional Comments: _____

_____

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CC: Service coordinator
Residential Setting
Day program