CARE HORIZON

Current Medication Form

Name_____ Date_____

Preferred Pharmacy_____ Pharmacy Phone Number_____

Medication (psychoactive, non-psychoactive, over-the counter, herbal, folk remedies)	**Dosage** Example- 50mg.	**Frequency and instructions for use** Example- twice daily	**Prescribing Professional**	**Effectiveness/ Response to medication**	**Date Began**	**Date Ended**

Use back of sheet if necessary

Allergies/past adverse reactions:_____

Signature of Person Completing Form_____

Relationship to person enrolling in services: € Self € Guardian € Other: Detail _____