

Marion Somers, Ph.D.
Geriatric Care Manager
www.DoctorMarion.com

Pharmacy: Name _____
Address _____
Phone # _____ Fax # _____

Primary Doctor: Name _____
Address _____
Phone # _____ Fax # _____

CLIENT: _____

DATE: _____

Medication	Rx #	Doctor	Dosage	Frequency	Diagnosis	Color/Size of Pill
Over-the-counter:						

Discontinued medications:

CLIENT: _____

DATE: _____

* Pre-Breakfast	Breakfast	* Pre-Lunch	Lunch	* Pre-Dinner	Dinner	* Pre-Bedtime	Bedtime	
TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	**TOTAL

* "Pre-" = approximately 1 hour before

** Total number of pills for the day