MEDICINES ADMINITRATION RECORD (M.A.R.) Ref XPMD 03

(Affix Photo Here)

NAME: _____RECEIVED BY:_____

DOB:_____SIGNED:_____

GP.:_____GP. PHONE:_____

ADDRESS:_____POSTCODE:_____

AMOUNT RECEIVED	MEDICATION NAME (including strength and any 'Homely Remedies')	DOSE	TIME DUE	ROUTE (eg. oral, topical etc.)	DATE		DATE		DATE		DATE		AMOUNT RETURNED
					DOSE CHECKED	DOSE GIVEN	DOSE CHECKED	DOSE GIVEN	DOSE CHECKED	DOSE GIVEN	DOSE CHECKED	DOSE GIVEN	

Medication received from : _____ (/ /20__) Medication returned to : _____(/ /20__)

Is there enough of each medicine to last the required amount of time (please tick)? Yes ☐ No ☐ If No, Please give reasons_____

MEDICINES PROFILE (see M.A.R. for further information)

'As Required' medication instructions for use:

Medication name	**Instructions for use**

Details of any known medicine sensitivity (eg. to penicillin or aspirin):

NOTES (to include advice/instructions received from GP/Pharmacist with dates, times and methods (container label/phone/fax etc.)):

Explanation of any administration errors on this sheet:

Details of any medication refused on this sheet:

Details of any medication stopped and by whom: