Rehabilitation Associates, Inc.

MEDICATION LIST

Patient Name: _____
Patient DOB: _____
Date of Eval: _____

ROUTE METHODS

ID = INTRADERMAL (UNDER SKIN)
IM = INTRAMUSCULAR
IV = INTRAVENOUS
PO = BY MOUTH
PR = BY RECTUM
SUBQ = UNDERSKIN
SL = UNDER THE TONGUE
SUPP = SUPPOSITORY
RIGHT EYE = (no abbreviation)
LEFT EYE = (no abbreviation)

FREQUENCY TYPES

AC = BEFORE MEALS
PC = AFTER MEAL
PRN = WHEN NECESSARY
EVERYDAY = (no abbreviation)
EVERY OTHER DAY = (no abbreviation)
EVERY HOUR = (no abbreviation)
2X/DAY = (no abbreviation)
3X/DAY = (no abbreviation)

OFFICE USE

Medication	Prescribing MD	Dosage	Frequency	Route	Modifications while on program
1.					○ Add _____ ○ Stopped taking _____ ○ Modification as noted _____ ○ Therapist Initials/Date: _____
2.					○ Add _____ ○ Stopped taking _____ ○ Modification as noted _____ ○ Therapist Initials/Date: _____
3.					○ Add _____ ○ Stopped taking _____ ○ Modification as noted _____ ○ Therapist Initials/Date: _____
4.					○ Add _____ ○ Stopped taking _____ ○ Modification as noted _____ ○ Therapist Initials/Date: _____
5.					○ Add _____ ○ Stopped taking _____ ○ Modification as noted _____ ○ Therapist Initials/Date: _____
6.					○ Add _____ ○ Stopped taking _____ ○ Modification as noted _____ ○ Therapist Initials/Date: _____
7.					○ Add _____ ○ Stopped taking _____ ○ Modification as noted _____ ○ Therapist Initials/Date: _____
8.					○ Add _____ ○ Stopped taking _____ ○ Modification as noted _____ ○ Therapist Initials/Date: _____

Therapist Initials: _____ Therapist Signature: _____ Therapist Initials: _____ Therapist Signature: _____