MEDICATION FORM OF _____

YOUR NAME HERE

Complete this form, make copies and keep them in your ***Aware in Care*** kit. At the hospital, share your completed **Medication Form** when you are asked to provide a list of medications. Fill out a new form when your prescriptions change and keep this updated version in your kit.

Important names and numbers:

Care Partner	Relationship	Phone/Fax
Parkinson's Doctor or Neurologist		Phone/Fax
Primary Care Physician		Phone/Fax
Pharmacy		Phone/Fax

Basic Information:

I was diagnosed with Parkinson's disease in _____ (year).

I have a Deep Brain Stimulation device. ☐ Yes ☐ No

I also have the following conditions (check box):

☐ Constipation	☐ Diabetes	☐ Melanoma	☐ Other:_____
☐ COPD	☐ Heart Disease	☐ Osteoarthritis	_____
☐ Depression	☐ Hypertension	☐ Urinary Incontinence	_____

Medication List:

List all medications you are taking for Parkinson's and other conditions, including over-the-counter medications and supplements.

Medication	Dosage	Frequency/Timing	Condition Treated	Started