MEDICATION FLOW SHEET

Last name:______________________ First Name: __________________ MI: ________

Pt #: ____________________ DOB: _______________

Male □ Female □

Pharmacy Name: _________________________________

Pharmacy Phone #: ______________________________

Allergies: ___________________________
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Date	Start/Stop Dates	Medication	Dose/Route/Frequency	Pt. Med Education/Source*	Prescriber	Refills* (date, amount, initials)			
						1st	2nd	3rd	4th

* Patient education **'Source'** may be written, verbal, video, or web-based; **Refills** should follow strict office policy, requiring patient be seen at regular intervals (frequency to depend on drug indications and medical condition)