Medication Action Plan

Any issues or problems that you may have with your medications are listed below. Also listed are concerns that you or our pharmacist brought up during your visit. Our pharmacist has listed the steps that you can take to fix or avoid these problems.

Patient Name _____ Date of Birth_____

Primary Physician_____

Date: _____

Medication or Condition of Concern Issue or Problem: _____

_____

How you can fix the problem: _____

_____

Date: _____

Medication or Condition of Concern Issue or Problem: _____

_____

How you can fix the problem: _____

_____

Date: _____

Medication or Condition of Concern Issue or Problem: _____

_____

How you can fix the problem: _____

_____

Date Prepared: _____ Physician's Phone Number: _____

Remember to call if you:

1. Have questions
2. Are feeling ill and thinking of going to ER
3. Immediately you are hospitalized