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| NAME: |  | D.O.B.: |  |
| ADDRESS: |  | TEL NO: |  |
| MEDICAL HISTORY: |  |
| ALLERGIES/SENSITIVITIES: |  |
| NAME OF DOCTOR: |  | DOCTOR TEL NO: |  |
| SURGERY NAME/ADDRESS: |  |
| MM FORM IN PLACE? | YES/NO/NA | WHERE ARE MEDICINES STORED? |  |
| CREAMS REQUIRED? | YES/NO | IF YES, IS A TOPICAL MEDICINES APPLICATION RECORD IN PLACE? | YES/NO |

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| Key: | S = Service User Self-Administered | F = Family administered | O = Other | HP = Health Professional administered |
| V = Verbal Reminder | N = Nausea/Vomiting | P = Physical Assistance | G = Given by other |
| WD = Wasted and destroyed | R = Refused | NR = Not required | DC = Discontinued |

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| DATE | COMMENTS SECTION (Please record any further information below) |
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Completed by: ………………….………………………………(RRO/SSW/Supervisor) Date: ……………

Checked/Counter-signed by: …………………………………… (First Support Worker) Date: ……………. Page 2 of 2