# Medicines List:

## Helping you keep track of your medicines

My name: ______________________

My allergies or previous problems:

______________________

______________________

My emergency contact(s) details:

______________________

______________________

My GP/specialist contact details:

______________________

______________________

My pharmacy: ______________________

My pharmacist(s): ______________________

My palliative care team (eg, careworker, nurse):

______________________

______________________

______________________

Insert name of your organization

**Reminders:**

- **Ask a member of your care team to help you fill out this form.**
- **Bring this form to any future medical appointments.**
- **Include non-prescription medicines.**

| Name of medicine | What it looks like | How much and when | How to take it | Date started | What the medicine is for |
|---|---|---|---|---|---|
| Example only | eg, round, red, blue, white liquid | eg, one capsule per day | eg, by mouth, with food, by injection | dd/mm/yy | eg, pain |
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