Medicines List:

Helping you keep track of your medicines

Insert name of your organization

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):

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