Medication List

Name: DOB: M/F Ethnicity:

Allergies: Advance Directive Discussion Date:
Copy of Advance Directive in Chart: Y/N

Pharmacy:______________________________ Phone:______________

Date	Medication, Dosage, Directions	Refills				Stop Date
		Date	Freq / Qty	# Refills	Initials	

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***HEDIS® Requirement** – HEDIS® is a registered trademark of the National Committee for Quality Assurance. Quality reviews are performed annually on randomly selected patients. Keeping this form updated will reduce the need for excess medical record copying during the HEDIS Medical Record Review.