PARKINSON'S DISEASE

# Medication Form

**Complete this form, make copies and keep them in your Aware in Care kit. At the hospital, share your completed Medication Form when you are asked to provide a list of medications. Fill out a new form when your prescriptions change and keep an updated version in your kit.**

**YOUR NAME** | **DATE FORM FILLED**

## Important names and numbers

**CARE PARTNER** | RELATIONSHIP | PHONE/FAX

**PARKINSON'S DOCTOR OR NEUROLOGIST** | PHONE/FAX

**PRIMARY CARE PHYSICIAN** | PHONE/FAX

**PHARMACY** | PHONE/FAX

**I was diagnosed with Parkinson's disease in** ________ (year).

## Special Considerations

If any of the following are checked, please consult the Special Considerations of the Hospital Action Plan booklet in the Aware in Care Kit for more information.

- ○ I have a deep brain stimulation device.
- ○ I have Parkinson's disease-related dementia
- ○ I get dizzy or feel faint.
- ○ I have special dietary needs.
- ○ I have a Duopa Pump.
- ○ I have balance issues.
- ○ I have trouble swallowing.
- ○ I experience hallucinations or delusions as part of my Parkinson's.
- ○ I sometimes feel disoriented or confused in a way that is not normal for my Parkinson's.
- ○ Other:

**I also have the following conditions (check box):**

| | | | |
|---|---|---|---|
| ○COPD | ○Diabetes | ○Hypertension | ○Osteoarthritis |
| ○Depression | ○Heart Disease | ○Melanoma | ○Other: |

**Contraindicated medications or allergies:**

Aware in Care

Parkinson's Foundation

## Medication List

List all medications you are taking for Parkinson's and other conditions, including over-the-counter medications and supplements.

| TIME | MEDICATION | DOSAGE | NOTES |
| --- | --- | --- | --- |
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