R3 Cumbria Care Medication Administration Record (MAR)

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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

Medication Details	Time	w/c:	Day:	w/c:	Day:	w/c:	Day:	w/c:	Day:

Route:		Day Started:		Date Started:	

Medication Details	Time	w/c:	Day:	w/c:	Day:	w/c:	Day:	w/c:	Day:

Route:		Day Started:		Date Started:	

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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Medication Details	Time	w/c:	Day:	w/c:	Day:	w/c:	Day:	w/c:	Day:
Route:		Day Started:			Date Started:				

Medication Details	Time	w/c:	Day:	w/c:	Day:	w/c:	Day:	w/c:	Day:
Route:		Day Started:			Date Started:				

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: ……