dacs
DEMENTIA & AGED CARE SERVICES

CLIENT MEDICATION ASSESSMENT

Client Name:	**Client Date of Birth:**

These questions should be answered in the context of self-administration of medications. A client's ability to self-administer medications should be reviewed at regular intervals (3-6 months) or if a change in the clients medical condition, hospitalisation or changes in medication occurs, or if the medication regime becomes more complicated.

1	Does the client wish to self-medicate?	☐Yes ☐No
2	Is the client already self-medicating at home?	☐Yes ☐No
3	Is the client using a dose administration aid at home?	☐Yes ☐No
4	Is the client oriented in time and place?	☐Yes ☐No
5	Does the client have a history of alcohol or drug abuse?	☐Yes ☐No
6	Does the client have any cognitive disabilities?	☐Yes ☐No
7	Does the client have gross/fine motor skills deficit?	☐Yes ☐No
8	Is the client able to communicate effectively?	☐Yes ☐No
9	Does the client have a visual impairment?	☐Yes ☐No
10	Can the client open the following	
	○ Bottles with normal lids?	☐Yes ☐No
	○ Bottles with child resistant closures?	☐Yes ☐No
	○ Foil packets?	☐Yes ☐No
	○ Boxes?	☐Yes ☐No
	○ Does administration aids?	
11	Can the client unlock and open the draw in which their medications would be stored?	☐Yes ☐No
12	Can the client read the labels on their medications?	☐Yes ☐No
13	Does the client understand what the medication(s) are/is for?	☐Yes ☐No
14	Does the client know what to do if they?	
	○ Miss a dose?	☐Yes ☐No
	○ Take a wrong dose?	☐Yes ☐No
15	Can the client identify the medication?	☐Yes ☐No
16	Can the client prepare the correct amount of medication?	☐Yes ☐No
17	Can the client administer eye drops/ointments?	☐Yes ☐No
18	Can the client administer ear drops?	☐Yes ☐No

Medication Use Assessment		
It may be necessary to assess the clients use/deliver of other medications (eg, per vagina or per rectum, patches or inhalers). Please document the clients ability to self-administer any other medications prescribed that have not been covered:		
Are there any strategies which may assist the client to self-administer?		
Is the client capable of self-administering any of their medications? If yes please list		
Assessment Completion		
Name of person completing the assessment:		Designation:
Date and time assessment completed:	Signature:	
Date uploaded to iCare:		
Review		
Changes to the current self-medication plan?		
Name of person completing the review:		Designation:
Date and time review completed:	Signature:	
Date uploaded to iCare:		