dacs
DEMENTIA & AGED CARE SERVICES

# CLIENT MEDICATION ASSESSMENT

| Client Name: | Date of Birth: |
|---|---|

These questions should be answered in the context of self-administration of medications. A clients ability to self-administer medications should be reviewed at regular intervals 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? | ☐ Yes ☐ No |
| 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 (e.g., 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?<br>If yes, please list. |

| Assessment Completion |
|---|
| Name of person completing the assessment: |
| Designation: |
| Date and time assessment completed: |
| Signature: |
| Date uploaded to VisualCare: |

| Review |
|---|
| Changes to the current self-medication plan? |
| Name of person completing the review: |
| Designation: |
| Date and time review completed: |
| Signature: |
| Date uploaded to VisualCare: |