

Date: _____

Dear _____,

Thank you for talking with me on _____, about your health and medications. As a follow-up to our talk, **I've included two lists:**

1. Your **Recommended To-Do List** has steps that you should take to get the best results from your meds.
2. Your **Medication List** will help you keep track of what you take and how to take it.

If you want to talk about these lists, please call _____ at _____

I look forward to working with you and your doctors to make sure your meds work well for you.

Sincerely,

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB number for this information collection is 0938-1154. The time required to complete this information collection is estimated to average 40 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850

Medications for _____, DOB: _____

Recommended To-Do List

Prepared on: _____

You can get the best results from your medications by completing the items on this **“To-Do List.”**



Bring your **To-Do List** when you go to your doctor. Be sure to share it with your family or others who care for you.

My To-Do List

TOPIC 1 What we talked about:	TOPIC 1 What action I should do: ☐ _____ ☐ _____
TOPIC 2 What we talked about:	TOPIC 2 What action I should do: ☐ _____ ☐ _____
TOPIC 3 What we talked about:	TOPIC 3 What action I should do: ☐ _____ ☐ _____

TOPIC 4

What we talked about:

TOPIC 4

What action I should do:

☐

☐

Medication List

Prepared on: _____



Bring your Medication List when you go to the doctor, hospital, or ER (emergency room). Be sure to share it with your family or others who care for you.



Note any changes to how you take your meds.
Cross out meds when you no longer use them.

Medication	How I take it	Why I use it	Prescriber (Doctor)

Medications for _____, DOB: _____



Add new medications, over-the-counter drugs, herbals, vitamins, or minerals in the blank rows below.

Medication	How I take it	Why I use it	Prescriber (Doctor)



Allergies:



Side effects I have had:



Other information:



My notes and questions: