

**Medication Therapy Chart**

Clients' Name:		NHI:		Medications:		Medical History:		
DOB:								
ACC : Yes/No		Claim #:		Allergies:		(also complete a Clinical Note)		
Date	Time	Route	Medication Administered	Dose	Batch	Expiry	RN Administrator	Observations <small>(for client having IV meds or condition of concern)</small>