NHS
Kent and Medway

Medicines Administration Record Front Cover

Resident name:			
Date of Birth:		**Room Number:**	
Allergies: Please provide the reaction type if known			
GP:		**GP Practice**	
Photo:			
Date photo taken:			
How I like to take my medicines:			
I self-administer my medicines:	☐ YES ☐ NO	**If not all medicines, list which medicines are self-administered**	
I receive my medicines covertly:	☐ YES (*see relevant documents for further details*) ☐ NO		
I have swallowing difficulties:	☐ YES (*see relevant documents for further details*) ☐ NO		
Date Completed:			
Completed by: Name and role			
Review date:			