# Medication Addendum

| Data Field | Client Information |
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| **Person's Name (First, MI, Last)** | Record first name, middle initial, and last name of the person served. Order of name is at agency discretion. |
| **Record Number** | Record agency's established identification number for the person. |
| **Date of Admission** | Record date the person served was admitted. |
| **Organization/ Program Name** | Record the organization and program for whom you are delivering the service. |
| **DOB** | Document date of birth of the person served. |
| **Gender** | Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes. |

| Data Field | Medication Information |
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| **Medication** | Record past and current psychiatric and non-psychiatric medications, prescribed by a licensed prescriber or self-prescribed, as well as over the counter and/or herbal medications and supplements. The information should be captured even if the person does not know the name of the medication. If this is the case, in the Medication column list "unknown" and then list all other information the person remembers. This is especially important for current medications that the person is taking. Include what medications work well and have worked well previously, any adverse side effects, why person doesn't take medication as prescribed and/or which one(s) the person would like to avoid taking in the future. |
| **Rationale/ Condition** | Indicate the symptoms or diseases for which the medication was/is used. |
| **Dosage / Route / Frequency** | Record the dosage, route, and frequency for each medication taken by the person. It is suggested that dosage be recorded as unit/time of day. **Example: 50 mg by mouth @ 8 AM, 3 PM and 10 PM.** |
| **Reported Side-effects** | Record any reported side-effects. Document the degree of distress the person experienced or experiences due to each side-effect. |
| **Adherence** | Check the box that best indicates if the person takes the medication as prescribed or suggested, or if the person needs assistance to adhere to the medication regimen. |
| **Prescriber** | Record the name of the physician or other licensed prescriber who prescribed the listed medication. |
| **Data Field** | **Comments on Medications** |
| **Comments on Medications** | Note which medications have been tried in the past indicating which ones have worked well or not. Record relevant comments, including reasons for discontinuation of the medication, why person doesn't take meds as prescribed, side-effects and any specific medications the person would like to avoid taking in the future. |

| Data Field | Signatures |
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| **Person's Signature** (Optional, if clinically appropriate) | The person served **should** be given the option to sign the IAP. If the person served does not sign, list the reasons and an explanation on the IAP form, or document the reasons in a Progress Note and list the date here. |
| **Date** | Date of person's signature. |
| **Parent/Guardian Signature** | The signature of parent, guardian, or other legal representatives should be obtained when applicable. The provider should consult with his/her local provider agency's internal policies and procedures regarding the need for signatures of parents, guardians and other legal representatives. |

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| **Date** | Date of Parent/Guardian Signature. |
| **Clinician/Provider – Print Name/Credential** | **Legible** clinician/provider name and credentials, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan. |
| **Date** | Date of this signature. |
| **Supervisor – Print Name/Credential (if needed)** | If applicable, **legibly** record signature and credentials of supervisor. |
| **Date** | Date of this signature. |
| **Clinician/Provider Signature** | **Legible** signature, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan. |
| **Date** | Date of this signature. |
| **Supervisor's Signature (if needed)** | **Legible** signature and credentials of supervisor.<br><br>**Example: Jerry Smith, LMHC** |
| **Date** | Date of this signature. |
| **Physician/MD/DO Signature (if required)** | **Legible** physician's signature if required by agency policy. Please note certain payers do require physician's signature.<br><br>This is a requirement for Opiate Treatment Programs |