CARE 24/7 HEALTHCARE

Care 24/7 Healthcare Limited
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MM12

Covert Medication - Review of Continued Need

A: SERVICE USER DETAILS		
Surname:	**First Name(s)**	**Date of Birth:**
Pharmacist:	**GP:**	**Advocate:**

B: MEDICATION BEING ADMINISTERED

MEDICINE: _____

Formulation: (e.g. tablet / capsule / liquid / syrup) _____ Dosage: _____

C: REVIEW OF MEDICATION

#	CONSIDERATION	COMMENTS & OUTCOME
1	Is the medicine still necessary as part of the service user's overall medication regime?	☐ YES / ☐ NO If YES, give reasons:
2	Is covert administration of the medicine still necessary?	☐ YES / ☐ NO If YES, give reasons:
3	Is all the necessary legal documentation still in place?	☐ YES / ☐ NO If NO, give reasons:
4	Date of this Review: _____	**DATE OF NEXT REVIEW:** _____

PERSONS CONSULTED AS PART OF THE REVIEW ("Designation" = Job Position, or relationship to service user, as appropriate):

Name: _____ Designation: _____ Signature: _____ Date: _____

Name: _____ Designation: _____ Signature: _____ Date: _____

Name: _____ Designation: _____ Signature: _____ Date: _____

Name: _____ Designation: _____ Signature: _____ Date: _____

Name: _____ Signature: _____ Date: _____
Registered Manager)