



Good Practice Guidance for Care Homes							
Covert Medication Review Form							
Name:			Date of Birth:				
Care Home:				Date:			
Completed by:			Position:				
Shared decision making regarding covert administration of medicines must be clearly documented. This document should be used to provide evidence of review of the <u>continued need</u> for covert administration of medicines for the named individual.							
Are all medicines still necessary?		Yes / No					
Date of last medication review		Date NOTE: The covert medication plan should be updated completely if there were significant changes to medicines in the review					
Is covert administration still necessary? If so, explain why.							
Who was consu of the review?	ulted as part						
Is any appropri documentation place and valid DoLs?	still in						
Print Name (person leading I	review)			Date:			
Signed:				Position:			
Counter signed:				Date:			
Date of next rev	view						

MOVP-004 - V3 - Good Practice - Covert Medication Review		
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Review form		
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