North of England Commissioning Support Unit

Good Practice Guidance for Care Homes

Monthly Medication Tracker Sheet

List all current medicines including hospital medicines, inhalers, creams and all "when required" medicines

Resident Name:		**Date of Birth:**		**Room number:**		**Date:**	

Medication*	Strength	Form	Dose & frequency	Quantity remaining & in date	Quantity ordered	Date prescription requested	Date prescription received	Comments e.g. any discrepancy or action required	Date prescription sent	Date medication received	Comment e.g. any discrepancy or action required

Completed by:		**Date:**		**Checked by:**		**Date:**	

*Highlight if a medication is to be ordered/obtained from anywhere except GP practice/community pharmacy this may include anti-psychotics from mental health services, special hospital medication, nutritional supplements (PEG Feeds etc.) or catheter and leg bags from home delivery companies