Queensland Government

Young Person's Medication Change Plan
(three times a day medication)

Facility: .....

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Responsible Consultant:

Date document created: **Current weight:**

Medication changes advised

	Medication 1: (name, preparation e.g. tablet, strength)			**Medication 2:** (name, preparation e.g. tablet, strength)		
Week / Day Number (circle)	**AM dose (mg or mLs)**	**Day-time dose (mg or mLs)**	**PM dose (mg or mLs)**	**AM dose (mg or mLs)**	**Day-time dose (mg or mLs)**	**PM dose (mg or mLs)**

Who to contact if concerns arise during medication changes (e.g. side effects)

Name:	Position:	Contact (phone/page):

Completed by:

Doctor's name:	Position:	Contact (phone/page):
Institution:	Signature:	Date:

DO NOT WRITE IN THIS BINDING MARGIN

v1.00 - 02/2014

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